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**Doctorate in Clinical Psychology**

**An evaluation of the therapeutic alliance: A comparison between  
clients sexually abused as children and non-abused clients**

**Claire Middle**

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## **ABSTRACT**

This exploratory study aimed to investigate whether clients who have experienced childhood sexual abuse (CSA) differ from clients who have not disclosed such abuse, in the quality of the therapeutic alliance, level of interpersonal difficulties and in the elements viewed as important in the alliance. The study used both quantitative and qualitative methodologies. Standardised questionnaires were used to investigate differences in alliance and interpersonal difficulties. Grounded theory was used to investigate the factors that were important in the therapeutic alliance for clients with a history of CSA.

The women interviewed in the CSA group reported significantly lower scores than women in the non-CSA group on the Working Alliance Inventory, although overall scores for both groups were high. There were no overall significant differences in the level of interpersonal difficulties between the two groups, although the groups did differ on one sub-scale of the Inventory of Interpersonal Problems 32.

The qualitative analysis suggested that clients from both groups raised many similar issues as important in the therapeutic alliance. These included factors relating to the therapist, to the therapy and to the client's perception of the relationship. The issues of commitment, being believed, and the therapist not showing negative reactions were mentioned only by the survivors of CSA. Overall, the qualitative analysis revealed that a wide range of factors were relevant to both groups of clients, although the factors of commitment and therapist's reactions may be particularly relevant to work with survivors of childhood sexual abuse.

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# **1. INTRODUCTION**

## **1.1 Therapeutic alliance**

### **1.1.1 Theoretical basis**

The concept of the therapeutic alliance originated in the psychoanalytic tradition and has been adopted and used within a broad range of theoretical approaches including behavioural, cognitive-behavioural and experiential therapies (Gaston, Goldfried, Greenberg, Horvath, Raue & Watson, 1995). Freud first wrote about alliance in 1912 and referred to the positive relationship between the client and therapist (Freud, 1966). He initially viewed this as positive transference. Later, therapeutic alliance became recognised by Freud and others as separate from transference. Greenson (1965) coined the term “working alliance” to refer to the collaboration between the therapist and client that is based in reality. Gelso & Carter (1985) described the client-therapist relationship as consisting of three components, the working alliance, the transference relationship and the real relationship. The concept of alliance has been referred to as the working alliance, the therapeutic alliance and the helping alliance (Horvath, Gaston & Luborsky, 1993). I shall use the terms “therapeutic alliance” and “working alliance” interchangeably to refer to this generic construct.

Different theoretical approaches have shared ideas about the therapeutic alliance, and have adapted the notion of the alliance to their particular model. The representation proposed by Bordin (1979) has been influential to the construct of the alliance, and has been adopted by different theoretical orientations. Bordin defined alliance as a pantheoretical formulation emphasising the clients’ positive collaboration with the therapist against the common foe of pain and self-defeating behaviour. He identified



three components of the alliance, the therapeutic bond, agreement about the goals of therapy and agreement of the tasks of therapy. The bond refers to the sentiments the therapy participants have for each other, the goal is the target of the intervention and the tasks are the elements that form the substance of therapy.

Therapeutic alliance, whilst broadly adopted, has been defined in different ways by different theoretical approaches. All discuss it as a relationship between the therapist and client that positively aids the therapy, but different theoretical orientations vary in the role and importance they place on alliance in the therapeutic process. Traditionally, behavioural therapists have placed little emphasis on alliance and view it as secondary to the specific techniques of behaviour therapy (Raue & Goldfried, 1994). Whilst cognitive therapists do not consider the alliance the central factor of their therapeutic approach, they view the therapeutic relationship as an important factor in enabling therapy to take place (Beck, Rush, Shaw & Emery, 1979). Psychodynamic psychotherapy describes alliance as the vehicle of therapy itself (Gaston et al., 1995). Experiential therapies draw on the Rogerian characteristics of warmth, genuineness and empathy to define the bond between the client and therapist, and view the relationship as important in the change process (Watson & Greenberg, 1994). The latter also distinguishes between relationship conditions and working conditions, similar to Bordin's conceptualisation of the bond as separate to the tasks and goal of the alliance. Beck et al. (1979) also adopted the Rogerian concepts of warmth, genuineness and empathy, in addition to the concept of collaboration, as important factors of the therapeutic relationship.

Despite the fact that alliance arose originally from the psychodynamic tradition, researchers have found that clients receiving cognitive-behavioural therapy report levels of therapeutic alliance equal to, or higher than, clients receiving psychodynamic-interpersonal therapy (Raue, Goldfried & Barkham, 1997).

### **1.1.2 Therapeutic alliance and outcome of therapy**

Research has shown that the therapeutic relationship is an important indicator of therapeutic outcome for different forms of psychotherapy including psychodynamic, experiential and cognitive-behavioural therapy (Luborsky, 1986). Outcome of therapy has been found to correlate with commonly used measures of therapeutic alliance for a range of problems including substance abuse, depression and personality disorder (Luborsky, Barber, Siqueland, McLellan & Woody, 1997; Castonguay, Goldfried, Wiser, Raue & Hayes, 1996; Gerstley, McLellan, Alterman, Woody, Luborsky & Prout, 1989). The length and type of treatment does not alter the predictive nature of alliance (Horvath & Symonds, 1991), neither is the severity of the client's distress predictive of the alliance (Marziali, 1984). Poor therapeutic alliance has also been found to be associated with dropout from therapy (Samstag, Batchelder, Muran, Safran & Winston, 1998).

Rather than good alliance predicting a positive therapeutic outcome, some have argued that the association may instead be a product of a "halo" phenomenon whereby clients who perceive the outcome of therapy as favourable are also likely to give a favourable bias to elements of the therapy. Horvath and Symonds (1991) investigated this suggestion and reported that they found no evidence of a "halo" effect. They concluded



that alliance is more than just a reflection of clients' general disposition towards therapy.

Research has further investigated the question of whether alliance is a by-product of therapeutic gains by studying the development of alliance over more or less successful episodes of therapy. The evidence suggests that rather than positive outcome being associated with a linear development of alliance, it is associated with positive outcomes of ruptures that occur in the alliance during therapy (Horvath et al., 1993).

### **1.1.3 Therapeutic alliance and interpersonal problems**

Both clients and therapists bring their own unique capacities to the development of the therapeutic alliance (Horvath et al., 1993). Interpersonal and intrapersonal client variables have been found to have a significant impact on alliance. Clients who have had successful pre-therapy family and social relationships are more likely to form a collaborative and positive alliance than clients who have had conflicted relationships (Marziali, 1984). Pre-therapy family and social relationships have been found to be more predictive of therapy outcome than pre-therapy psychological problems (Moras & Strupp, 1982). Interpersonal problems, such as hostility and lack of social competency, are associated with poorer alliance (Muran, Segal, Samstag & Crawford, 1994), although social competencies have been found to be less predictive than the quality of parental bonds (Mallinckrodt, Coble & Gantt, 1995). An individual's quality of object relations, defined as a person's lifelong pattern of relationships, has also been found to be more predictive than recent relationships of alliance and outcome (Piper, Azim, Joyce, McCallum, Nixon & Segal, 1991). The quality of clients' family and early



relationships is, therefore, an important predictor of the quality of the therapeutic alliance.

Recent research suggests that it is common for ruptures to occur in the therapeutic alliance and that the outcome of therapy is related to the ability of the client and therapist to successfully repair these ruptures. Castonguay et al. (1996) found that strains tended to centre on intrapersonal issues, and that therapists who dealt with strains in the therapeutic alliance by focusing on the specific techniques of cognitive therapy had worse outcomes than therapists who focused on the client's feelings and methods of coping. They suggest that flexibility in using the cognitive approach is important, and that in order to repair problems in the alliance it may be necessary to incorporate interpersonal interventions into cognitive therapy.

#### **1.1.4 Client and therapist ratings of the therapeutic alliance**

Although measures of therapeutic alliance have been found to be predictive of therapy outcome, large differences exist between client and therapist's views of alliance (Bachelor, 1991; Hatcher, Barends, Hansell & Gutfreund, 1995). Clients place greater emphasis than therapists on therapist helpfulness, warmth and emotional involvement (Bachelor, 1991), and therapist friendliness and depth (Samstag et al., 1998). Therapists tend to place more emphasis on clarity of goals (Hatcher et al., (1995) and patient hostility (Samstag et al., 1998).

Marziali (1984) found that although there was significant agreement between client and therapist ratings of their relationships, therapists rated the relationship more negatively.

Client perceptions of the relationship have been found to be stronger predictors of therapy outcome than therapist perceptions (Luborsky, 1986), and therapist alliance scales have provided significantly poorer predictions of outcome than client scales (Horvath & Symonds, 1991). This may be due partly to the fact that therapist scales were developed by re-wording client scales, and partly as a result of counter-transference and the therapist misjudging the client's sense of the relationship (Horvath et al., 1993).

## **1.2 Childhood sexual abuse**

### **1.2.1 Definitions and prevalence**

It has become increasingly recognised that childhood sexual abuse (CSA) has been experienced by large numbers of men and women (Briere, 1992), and it has been associated with emotional and interpersonal difficulties in both childhood and adulthood (Faust, Runyon & Kenny, 1995; Kimerling & Calhoun, 1994). There is no agreed definition of childhood sexual abuse, with some definitions limiting CSA to physical sexual contact (Bifulco, Brown and Harris, 1994), whilst others refer to the age of the child and the abuser, or to the use of force or coercion (Briere, 1992). Mullen, Martin, Anderson, Romans and Herbison (1996) propose a broad definition of unwanted sexual advances to individuals under the age of 16 years which includes both contact and non-contact abuse, such as indecent suggestions and exhibitionism.

These differences in definition influence estimates of the incidence of abuse, and also the perceived psychological correlates. In a review of studies using national probability samples, Rind and Tromovitch (1997) report prevalence of CSA ranging between six to

36 percent of boys and between 14 to 53 percent of girls. Differences in estimated prevalence also arise from variations in the research methods employed, the type and amount of questions asked and the type of people questioned. For example, face-to-face interviews yield higher rates than postal surveys, (Bifulco, Brown and Adler, 1991).

### **1.2.2 Childhood sexual abuse and long-term outcome**

Childhood sexual abuse has been found to be associated with many psychological difficulties (Briere, 1992). Problems that are repeatedly associated with childhood sexual abuse include post-traumatic stress, low self-esteem, guilt, anxiety, depression, somatisation, dissociation, eating disorders, sexual problems and suicidality (Bifulco et al., 1991; Briere, 1992; Kimerling & Calhoun, 1994; Mullen et al., 1996; Rodriguez, Ryan, Vande Kemp & Foy, 1997). Whilst many clinical studies have found a strong link between CSA and adult psychological problems, Rind & Tromovitch (1997) point out in their review of national population studies that whilst CSA is associated with later difficulties, most survivors of CSA do not report long-term psychological problems. Mullen, Martin, Anderson, Romans & Herbison (1993) also showed that whilst many of the women they surveyed from a community sample did not show measurable mental health difficulties, there was an overall positive correlation between abuse and a range of psychological problems. Finkelhor (1990) points out that whilst CSA may be associated with later difficulties, sexual abuse is not associated with any unique pattern of symptoms or diagnoses.

CSA has been found to be associated with interpersonal difficulties and poorer interpersonal competence later in adult life (Newman Lubell & Peterson, 1998).



Difficulties include social isolation, insecurity, discord and inadequacy in relationships (Donaldson & Cordes-Green, 1994), and difficulty initiating and maintaining non-abusive relationships (Crowder, 1995). Some studies have shown greater disturbance in relationships with mothers, with little or no difference in relationships with friends (Newman Lubell & Peterson, 1998).

Crowder (1995, pp.33) writes that 'sexual abuse is a human-induced trauma and it has long-lasting repercussions on subsequent human relationships. The relationship with the abuser is often complex, consisting of both positive and negative forms of attention, and can lead to mixed loyalties to the abuser and general confusion about the distinction between safe and abusive relationships'. Alpher & France (1993) argue that abusive relationships significantly alter the context for social and personality development.

Sexual abuse is often experienced with other forms of abuse, which have also been found to influence longer-term psychological outcome. There can be a close relationship between sexual, emotional and physical abuse, all of which have been associated with long-term emotional and interpersonal difficulties (Mullen et al., 1996). Sexual abuse may be only one factor within a more complex picture of other abuse and a dysfunctional family environment, which leads to later difficulties (Llewelyn, 1997). Based on their finding that many abused individuals surveyed in the general population do not report long-term difficulties, Rind & Tromovitch (1997) suggest that a causal link between CSA and later difficulties cannot be assumed. The effect of mediating factors may be important in understanding the influence CSA has on later social and emotional functioning.

Increased risk of poor adjustment to CSA is associated with factors relating to the abuse experience itself such as type, severity, the use of force or coercion, duration, and age of onset of the abuse (Wyatt & Newcomb, 1990). Poor outcome is also associated with familial factors such as the status of the perpetrator, lack of maternal support, perpetrator substance abuse, physical abuse and maternal mental illness (Faust et al., 1995; Fleming, Mullen & Bammer, 1997). Reaction to disclosure of abuse has been found to have a mediating effect on later difficulties, such that those who receive a poor reaction report higher levels of psychological difficulties (Roesler, 1994). Aspects of personality, coping style and social support have all been proposed as mediating factors. Self-esteem, locus of control (Moran & Eckenrode, 1992) and attributional style (Gold, 1986) have been found to be possible mediators in adjustment to childhood abuse. Social support and coping strategies, such as disclosure and positive re-framing, have been associated with fewer difficulties (Runtz & Schallow, 1997; Himelein & McElrath, 1996). Bodily shame has also been found to mediate the relationship between childhood abuse and both depression and eating disorders in adulthood (Andrews, 1995; Andrews, 1997).

In summary, the literature suggests that the impact of CSA is influenced by a wide range of factors, including aspects of the abuse itself, the family and social environment, social support, and characteristics of the individual such as attributional and coping style.

### **1.2.3 Childhood sexual abuse and explanatory models**

The diversity among explanatory models of the impact of CSA reflects the range of

factors found to influence adjustment to CSA. There is a lack of consensus on which model to adopt in understanding the consequences of CSA (Llewelyn, 1997). Models have tended to focus on different aspects of the impact of abuse. For example, developmental models have focused on the impact that abuse has on the child's development, whilst later models have incorporated aspects of the personality and the environment.

### **1.2.3.1 Developmental models**

Cole and Putman (1992) proposed a model based in developmental psychopathology. They argued that incestuous abuse interferes with ongoing development in self and social functioning, which adversely affects the child's development of self-integrity, self-regulation and relationships with peers. They argue that this increases the risk of particular difficulties later in life, such as borderline personality disorder, eating disorder and somatisation.

They suggest that, in association with the effects of temperamental and familial factors, the child's developmental stage at the onset of the abuse is important in understanding later difficulties. For example, due to limited coping strategies of pre-schoolers, children victimised at this age may depend on denial and dissociative coping strategies. The development tasks dominant among children aged 7-9 years concentrate on cognitive and social competence. Children abused at this age may experience particular difficulties in adjusting to the increasing scope of social experience and have difficulty establishing friends and social relationships.



Attachment theory offers an explanation for the association between later interpersonal difficulties and difficult familial relationships in childhood. Bowlby (1973) suggested that children form an attachment with their primary care givers, and based on their experiences with these attachment figures, the child forms an internal working model which influences their capacity to form future relationships. Alexander (1992) proposed that sexual abuse is associated with an insecure or disorganised attachment with at least one primary care giver and suggests that the diversity of symptoms seen in adult survivors is consistent with the effects of disturbed attachment relationships. For example, the individual who experienced avoidant insecure attachment, characterised by physically and psychologically distant care giving, may report a sense of social isolation and estrangement from others as a result of avoiding close emotional relationships in adulthood.

Alexander concentrates her theory on the 'sexually abusive family' drawing on the findings of Finkelhor & Baron (1986) that certain family characteristics, such as absence of a biological parent, maternal unavailability and marital conflict, are predictors of increased risk of CSA. This account does not include children abused by someone outside their care system and the type of attachment relationships they may have.

These theories are useful in conceptualising the way abuse may affect the child's development and could be incorporated into wider theories of the impact of CSA. Cole & Putman (1992) suggest that by the nature of its definition, that CSA occurs in childhood, any comprehensive theory would need to include a developmental

perspective.

### 1.2.3.2 Traumagenic dynamics

The traumagenic dynamics model proposed by Finkelhor & Browne (1985) attempts to explain the traumatising effects of CSA. These researchers suggest four dynamics which result from certain aspects of the abuse situation; stigmatisation, betrayal, powerlessness and traumatic sexualisation. They suggest that these dynamics influence the person's psychological and interpersonal functioning and that, depending on the factors relating to the abuse experience, children experience these four dynamics to varying degrees.

Negative messages associated with CSA, both from the abuser and other adults, may result in a sense of *stigmatisation* and feelings of shame, guilt and lower self-esteem. *Betrayal* of the child's expectations of being cared for can result in negative emotions such as depression, mistrust, anger and dependency. As well as not being protected by adults, children experience *powerlessness* in not being able to protect themselves, which may result in anxiety and fear. *Traumatic sexualisation* refers to the development of misconceptions about sexual norms and behaviour, leading to distorted beliefs, emotions and behaviours relating to sexual activity. These dynamics have been suggested to mediate the long-term effects of CSA (Coffey, Leitenberg, Henning, Turner & Bennett, 1996) and lead to cognitive attributions such as those relating to shame (Feiring, Taska & Lewis, 1996).

This model focuses on the interpersonal and sexual aspects of abuse and the impact

these have on the child's psychological, emotional and social world. It has been an important model in understanding the impact and type of difficulties that have been found to be particularly associated with CSA. The model does not, however, incorporate the influence of potential mediating factors such as coping strategies and personality constructs, which can affect the impact of CSA (Spaccarelli, 1994).

#### **1.2.3.3 Transactional model**

Spaccarelli (1994) argues that integrative models of the impact of CSA are needed to specify how factors pertaining to the abuse itself, differences in coping and attributional style, and familial factors all contribute to longer-term outcome. Transactional theory emphasises that development proceeds through a series of person-environment transactions. Spaccarelli suggests that emotional and interpersonal difficulties result from the influence of the total abuse stressors, mediated by negative cognitive appraisals and unhelpful coping strategies. Further, he suggests that appraisal and coping strategies are moderated by environmental and individual variables such as social support, personality, age and gender. He suggests that the model is bi-directional such that the child's cognitive and behavioural responses to the abuse also influence their coping, appraisals and environment.

This model raises the idea of resilience by suggesting that style of coping and appraisal can serve as protective as well as risk factors (Spaccarelli & Kim, 1995). This is a comprehensive theory taking into account a wide range of variables in predicting the impact of abuse. However, it is also rather general and does not discuss how particular difficulties associated with survivors develop.



#### **1.2.3.4 Cognitive theory**

Cognitive theory was developed in the 1960's on the premise that conscious thoughts could themselves have an impact on feelings and behaviour (Brewin, 1996). Beck wrote about the relationship between the symptoms of emotional disorders and cognitive events, such as thoughts and images (Beck, 1976). He suggested three specific concepts to explain the psychological substrate of depression, the cognitive triad, schemas and cognitive errors (Beck et al., 1979). The cognitive triad consists of negative cognitive patterns in the way the individual views themselves, their future and their experiences. Beck described a schema as 'a structure used for screening, coding, and evaluating impinging stimuli' (Beck, 1964, p.562). They are enduring beliefs developed over many years, that represent the way an individual organises his or her past experience. Schemas and systematic errors in thinking serve to maintain long-term psychiatric problems including personality disorder, depression and relationship difficulties because they affect how incoming information is processed (Padesky, 1994).

Cognitive theory has been discussed in relation to CSA, in terms of the impact abuse have on shaping the child's inner world (Beck, Freeman, Pretzer, Davis, Fleming, Ottavani, Beck, Simon, Padesky, Meyer & Trexler, 1990). People can develop unhelpful schemas about themselves, others and the world, in response to negative life events such as childhood abuse (Beck et al., 1990, Padesky, 1994). Cognitive theories of the effects of abuse suggest that the individual draws conclusions from the abuse experience and the nature of the relationship with the abuser. For example, Janoff-Bulman (1985) proposed that victimisation shatters basic assumptions about the person being invulnerable, the world being meaningful and about positive self-perception.

Roth & Newman (1993) suggest that the experience of being treated as an object, or existing for the abuser's needs without regard for their own, may result in specific self and interpersonal beliefs.

*Cognitive therapy* has concentrated on identifying and reviewing unhelpful cognitions, including images, rules, assumptions and beliefs (Beck et al., 1979). Janoff-Bulman (1985) suggests that coping with victimisation involves rebuilding the "assumptive world". He suggests that the person is forced to reappraise their world by either assimilating trauma into their existing beliefs or by revising their beliefs to accommodate it. Jehu (1994) hypothesised that childhood sexual abuse results in the development of maladaptive schemas that are maintained by cognitive distortions, self-defeating behaviour and feelings of anxiety and hopelessness. In particular, he suggests that survivors may experience problems in the areas of safety, trust, self-esteem, control and intimacy. Roth & Newman (1993) argue that in addition to coming to a cognitive understanding of the meaning of the trauma, survivors also need to understand the emotional impact of the trauma so that they are no longer preoccupied by negative feelings.

Cognitive theorists have become increasingly interested in the therapist-client relationship, and Safran and Segal (1990) proposed a model incorporating interpersonal and cognitive theory. They suggest that an individual's interpersonal schemata develops from their interpersonal experience, and that traumatic interpersonal experience can lead to an individual developing negative interpersonal belief systems. These belief systems then impinge on subsequent relationships.



*The therapeutic approach* they propose advocates a Beckian cognitive approach based on collaboration, exploration rather than interpretation, modifying cognitive processes and understanding schemas, with a much greater emphasis on aspects of interpersonal therapy. They incorporate using the therapists' feelings and the therapeutic relationship to explore cognitive and affective processes, and to generate hypotheses about interpersonal patterns. Whilst this theory may prove to be useful when working with clients who present with interpersonal difficulties, its application and effectiveness is yet to be explored.

Other cognitive models used to guide therapeutic approaches with survivors of abuse are those which underpin Cognitive Analytic Therapy (CAT) and Dialectic Behaviour Therapy (DBT). In developing CAT, Ryle (1991) was initially influenced by Kelly's personal construct theory, and later by object relations theory. The underlying theoretical model of CAT is the Procedural Sequence Model where procedures are viewed as linked sequences of mental and behavioural processes. An important procedure outlined in CAT is the reciprocal role procedure. Reciprocal roles are viewed as interactions developed from early relationships. The infant learns two distinct roles, their own response to their caretaker's role behaviour and the caretaker's role itself (Ryle, 1995). This suggests that abused children develop the reciprocal roles of the victim and the abuser, although the latter may most often take the form of self-abuse (Clarke & Llewelyn, 1994).

*The therapeutic approach* utilises both cognitive-behavioural and psychodynamic therapeutic techniques (Ryle, 1991). Therapy involves identifying and modifying



ineffective or maladaptive procedures, which Ryle (1991) describes as traps, snags and dilemmas.

Linehan (1993) developed DBT through her work with para-suicidal and borderline personality disorder clients. She has integrated aspects of cognitive theory with a radical behavioural model. The mode of change is through the use of dialectics, and she states that 'dialectics refers to change by persuasion and by making use of the oppositions inherent in the therapeutic relationship, rather than by formal impersonal logic' (Linehan, 1993, p.34).

*Therapy* focuses on validating rather than blaming clients, and therapists seek to reinforce "good" behaviours and prevent "bad" behaviours through balancing their response to the oscillating nature of the patient's distress. Her therapy differs from CBT in that it promotes acceptance rather than a change of feelings and situations.

In summary, no one theory has been adopted to explain the impact of CSA. Rather, there is a range of models, each of which attempts to explain different aspects of the impact of abuse and provides the basis for the different therapeutic intervention used.

### **1.3 Therapeutic alliance and childhood sexual abuse**

Clients who have experienced sexual abuse during childhood might be expected to encounter more difficulty with the therapeutic relationship than other clients, given the difficult interpersonal experiences they have experienced. This is reflected in therapeutic approaches for survivors of childhood abuse, which emphasise the

importance of the therapeutic relationship (Lebowitz, Harvey & Herman, 1993). Clinicians stress the interpersonal issues of empowerment, safety, trust, client-focus, client-pace and boundaries as important issues in the relationship (Crowder, 1995; Hill & Alexander, 1993; Mitchel & Morse, 1998). Treatment approaches commonly advocate that therapists be empathic, supportive, accepting, respectful, empowering and collaborative (Crowder, 1995; Lebowitz et al., 1993). These factors are not likely to be exclusive to clients with abusive histories as studies have found that clients with other presenting problems favour therapist attributes such as warmth and helpfulness (Bachelor, 1991).

Whilst many of the factors of the therapeutic relationship are shared across all individuals entering therapy, the particular experiences of an individual will inevitably shape their particular requirements of their therapist. People who have experienced interpersonal abuse could be expected to differ from people who have not experienced interpersonal abuse by the factors that influence the ease with which they form a therapeutic relationship.

The therapeutic relationship with clients who have been abused may be more complex than for non-abused clients and assume more importance in the therapeutic process. Draucker (1999) found that the quality of the therapeutic relationship was considered more important than the techniques of their therapy for women who had experienced sexual assault. Hill & Alexander (1993, pp.420) write 'the working alliance seems to be particularly important for treating adult survivors because their experience of betrayal of a trust by someone in a position of authority is so germane to their abuse'.

Roth & Batson (1993) say that in treatment of incest survivors there is a dynamic process of recovery that ultimately involves integration of traumatic material which can only occur within the context of a meaningful therapeutic relationship. Thematic issues such as betrayal, self-blame, loss, shame and helplessness are considered important when defining the abusive dynamics. They see the therapeutic relationship as a vehicle to offer a safe and supportive environment in which to carry out trauma work.

The sex of the therapist may also be an important factor. Llewelyn (1997) suggests that insight into the tendency of survivors to repeat past relationships is crucial to guard against female clients forming harmful relationships by sexualising the relationship with male therapists or abdicating power to them. Jehu (1994) suggests that disclosure of sensitive and embarrassing information by patients may make patients vulnerable to exploitation. He also suggests that survivors of childhood abuse may be more vulnerable because of feelings of powerlessness, low self-esteem, need for approval, dissociation and unassertiveness.

## **1.4 The study**

### **1.4.1 Rationale and aims**

This exploratory study aims to investigate the therapeutic relationship among clients who have disclosed a history of childhood sexual abuse. The research literature suggests that the therapeutic alliance is an important predictor of the outcome of therapy and that the alliance is negatively associated with interpersonal difficulties, particularly relating to familial relationships. Interpersonal problems have been found to be prevalent among survivors of CSA, and may make it more difficult for these clients to



form positive therapeutic alliances. Whilst therapeutic approaches for working with survivors of abuse advocate the importance of the therapeutic alliance, there has been little research investigating alliance with this group of people. This study aims to investigate whether survivors of CSA report poorer therapeutic alliances compared to people who have not reported past abuse, and also whether survivors of CSA report more interpersonal problems compared to other clients. This study will investigate whether reported level of interpersonal problems is associated with scores of alliance for both groups of participants.

Previous research has found that clients tend to report higher scores on measures of therapeutic alliance and place more weight than therapists on the personal qualities of the therapist. Client and therapist ratings of the alliance will be compared to investigate whether clients' and therapists' views of the alliance differ.

This study also aims to investigate the elements clients view as important to the alliance. Whilst it may be useful also to establish whether alliance is related to therapy outcome, this would require a much more extensive design following up clients over a longer period. Instead this study takes its beginning from the generally accepted finding that outcome is highly associated with therapeutic alliance and concentrates on studying the alliance itself to provide a clearer understanding of what issues are particularly pertinent to survivors of CSA. The research and clinical literature suggest that interpersonal issues, such as trust, safety and power are particularly pertinent to survivors of abuse. These may, therefore, be prominent themes for survivors of CSA.

#### **1.4.2 Methodological issues**

Most studies specifically relating to survivors of CSA have used retrospective designs, which have particular methodological problems. A number of areas of bias may result from relying on subjective reports. Past experiences may affect on-going problems, and current mood could also affect an individual's account of past abuse. Reports of CSA may be affected by repression of memories, the possibility of inaccurate memories and a reluctance to report abuse due to stigmatisation. In retrospective reports it is possible that individuals could over-report past negative events in order to explain current symptoms, or conversely they could under-report events due to an unwillingness or inability to talk about past traumatic events (Bifulco, Brown, Lillie & Jarvis, 1997).

A causal relationship between CSA and later difficulties has not been established and difficulties in adulthood have been associated with a wide range of difficult childhood situations and environments. The inferences made from any study of survivors of CSA need to be cautious to protect from inferring causal relationships from a picture that is much more complex. Given the current uncertainties about the pathways between early childhood abuse and later psychological difficulties, Pilkonis (1993) suggests that it is appropriate to use descriptive methodologies in studies focused on interpersonal factors.

Research with survivors of abuse raises some particular ethical issues due to the sensitive nature of the research. Given that survivors have often experienced abuse of power and trust, the issues of confidentiality, consent and possible harm through distress need to be considered carefully (Hill & Alexander, 1993).



The therapeutic alliance has been conceptualised in different ways, which has provided the basis for the different measures of alliance. Hatcher et al. (1995) found that the different measures of alliance varied in the factors they measured and suggested that studies use multiple measures of alliance.

#### **1.4.3 Quantitative and qualitative methods**

Quantitative methods have long been established in applied psychological research. More recently, qualitative methodologies have been increasingly recognised and employed as valid and reliable methods (Clegg, Standen & Jones, 1996). Qualitative research methods are particularly suited to research where complex meanings of experience are being investigated, where existing theory seems exhausted or where little information about an area is available (Stiles, 1993). They are also suited to research involving vulnerable participants as they promote data collection procedures that are empowering for participants. The research interview also provides an opportunity to monitor the impact of taking part in the research.

Qualitative and quantitative methods approach the investigation of knowledge and understanding in different ways. At a practical level, qualitative research involves collecting non-numerical data, which is analysed using non-mathematical procedures (Stiles, 1993). The quantitative research paradigm regards knowledge as an objective truth that can be described by abstract and universal laws (Reason, 1981). In contrast, the qualitative approach regards knowledge as contextualised and local and argues that theory is built from the data rather than tested through data collection (Pidgeon, 1996).



This study uses a combination of both quantitative and qualitative approaches based on the assumption that different methodological techniques yield different types of data (Mason, 1994). For the quantitative part, data was collected using established questionnaires to test particular hypotheses and expectations about the association between CSA, quality of therapeutic alliance and level of interpersonal difficulties. The qualitative methodology of grounded theory was used to investigate the particular therapeutic relationship experiences of people to give a wider understanding than could be obtained by validated questionnaires alone. Grounded theory has previously been used to understand the psychotherapy process from the clients' perspective (Rennie, Phillips & Quartaro, 1988). It aims to generate an account inductively from the data through repeated immersion and categorisation of the interview data and to generate theory and meanings that are "grounded" in the data collected (Pidgeon, 1996).

#### **1.4.4 Research questions**

1. Do clients who have disclosed sexual abuse during childhood have lower scores on measures of therapeutic alliance compared to clients who do not report such abuse?
2. Do clients who have disclosed sexual abuse during childhood report more interpersonal problems than clients who do not report such abuse?
3. Is the reported level of interpersonal problems related to scores on measures of therapeutic alliance?
4. Do clients and therapists differ in their ratings of therapeutic alliance?
5. What factors do clients who have disclosed sexual abuse during childhood identify as important in forming the therapeutic alliance?

### **1.4.5 Hypotheses**

1. Clients who were sexually abused during childhood will have lower scores of therapeutic alliance than non-abused clients.
2. Clients who were sexually abused during childhood will report more interpersonal problems than non-abused clients.
3. Scores on the measures of therapeutic alliance will be inversely correlated with scores on the measure of interpersonal problems.
4. Clients and therapists will differ in their rating of therapeutic alliance factors for both abused and non-abused clients.
5. The two groups of participants will generate different accounts using qualitative analysis.

## **2. METHOD**

### **2.1 Design**

This study used a comparison of two groups design, comparing participants who had disclosed a history of CSA with participants who had not disclosed CSA. A mixture of quantitative and qualitative analyses was carried out. Participants completed a short battery of questionnaires and then took part in a semi-structured interview.

### **2.2 Participants**

#### **2.2.1 Pilot study**

A small pilot study was conducted to test the procedure and measures. For this, five participants were recruited from clients receiving therapy from psychologists working in

a Psychology Department.

### **2.2.2 Main study**

Participants were recruited from NHS clients seen at Psychology or Psychotherapy Departments. Participants were clients aged 18-65 years, who had either just finished a course of therapy or had attended a minimum of six sessions or six months of therapy.

The first group consisted of people who had disclosed a history of childhood sexual abuse. This was defined as “any unwanted sexual activity involving either non-contact or physical contact, which occurred before the age of 16”. The definition chosen is similar to that used by Mullen et al. (1996), and is deliberately broad to encompass both contact and non-contact abuse. It does not stipulate the age of the abuser and so does not exclude abuse from people of similar ages, such as siblings.

The second, or control group, consisted of clients who had not disclosed a history of CSA, who were being seen primarily for anxiety-related problems, although clients did not have to fulfil DSM IV (1994) diagnostic criteria.

For both groups, therapists were asked not to recruit clients who were being seen primarily for interpersonal difficulties. The groups were matched for age, sex and type of department where therapy was received.



## **2.3 Measures**

### **2.3.1 Questionnaires**

Two standardised measures of therapeutic alliance were administered, the Working Alliance Inventory (WAI) shown in Appendix 6.1.1, and the Revised Helping Alliance Questionnaire (HAQ-II), shown in Appendix 6.1.2. Participants were also given a standardised measure of interpersonal difficulties, the Inventory of Interpersonal Problems (IIP-32), shown in Appendix 6.1.3. The Client-Therapist Ratings Scale was devised to administer to clients and therapists, shown in Appendix 6.1.4.

#### **2.3.1.1 Working Alliance Inventory**

The WAI (Horvath & Greenberg, 1989) is based on Bordin's conceptualisation of the working alliance and was developed to apply to all forms of therapy. The 36 items of the WAI are equally divided into three sub-scales consistent with the three components of the working alliance defined by Bordin; tasks, bonds and goals.

It has been shown to be a reliable measure, with an estimated Cronbach Alpha for the whole instrument ranging from 0.93 to 0.84, and for the sub-scales between 0.92 and 0.68 (Horvath, 1994). Test-retest reliability across a 3-week interval was 0.80 for the whole test, and between 0.74 and 0.66 for the sub-scales. The WAI's validity has been well established. It has been found to correlate positively with other scales of therapeutic alliance, such as the California Psychotherapy Alliance Scale, with a total scale correlation of 0.87 (Safran & Wallner, 1991). The WAI has been demonstrated to show good predictive validity, with a positive relationship between alliance and outcome (Horvath & Symonds, 1991).

### **2.3.1.2 Revised Helping Alliance Questionnaire**

The HAq-II (Luborsky, Barber, Siqueland, Johnson, Najavits, Frank & Daley, 1996) focuses on whether the therapist is providing or able to provide the help needed, and whether there is collaborative effort. It consists of 19 items, which are rated on a six point scale from “strongly agree” to “strongly disagree”. It has demonstrated reliability, with Cronbach Alphas ranging from 0.90 to 0.93. Test-retest reliability was high at 0.78, and the correlation between session five and session 24 showed the measure to be relatively stable,  $r=0.34$ ,  $p<0.005$ . The HAq-II has been shown to have good convergent and discriminant validity, with correlations between the HAq-II and the California Psychotherapy Alliance Scale ranging from 0.59 to 0.69 (Luborsky et al., 1996).

### **2.3.1.3 Inventory of Interpersonal Problems 32**

The IIP-32 (Barkham & Hardy, 1996) is a standardised questionnaire developed to identify difficulties in interpersonal functioning. It is a shortened version of the original 127 item IIP (Horowitz, Rosenberg, Baer, Ureno & Villasenor, 1988). The 32-item revision retains the same structure as the original and asks about things that people find “too hard”, and about things that they do “too much”. The scale consists of a total score and eight sub-scales: hard to be sociable, hard to be assertive, hard to be supportive, hard to be involved, too aggressive, too open, too caring and too dependent.

The IIP-32 is a relatively reliable measure, with sub-scale alpha coefficients ranging from 0.71 to 0.89, and full-scale alphas of 0.86-0.90. It has good predictive validity, discriminating between clinical and normative samples, both on the full-scale score,  $t(252) = 6.82$ ,  $p<0.001$ , and the sub-scale scores examined together, Hotelling's  $T^2 =$

0.28,  $p < 0.001$  (Barkham & Hardy, 1996).

#### **2.3.1.4 Client-Therapist Ratings Scale**

This Likert scale was devised to provide a short measure to compare client and therapist views of their relationship. It contains five questions, three reflecting the themes of the three sub-scales of the WAI, and the remaining two reflecting the two main sub-scales of the HAQ-II. This scale was created to be simple and easy to complete as existing therapist standardised measures are lengthy and time consuming.

#### **2.3.2 Semi-structured interview**

In the semi-structured interview, outlined in Appendix 6.2, clients were first asked some demographic questions, including their age, sex, marital and employment status, living arrangements, previous psychological or psychiatric treatment, who their therapist was and the number of sessions they had attended.

They were then asked to talk about what they felt was important about the relationship they had with their therapist, both in terms of things that were helpful and unhelpful. They were told that there were no right or wrong answers and reminded that they did not need to talk about the content of their therapy. The initial question was repeated during the interview to draw out any additional views from the participant, and the researcher asked questions of clarification in response to the points raised by the participant. Some additional open-ended questions were asked if the participant found it difficult to talk freely. This followed the model of a “directed conversation” (Pidgeon & Henwood, 1996).



Reliability and validity are concepts that were developed within the quantitative paradigm to evaluate research (Reason, 1981). They are more difficult to apply to qualitative research, and some argue that it is not appropriate to do so (Silverman, 1993). However, validity and reliability criteria have been developed for qualitative analysis based on the concept of “trustworthiness” (Stiles, 1993). Stiles suggests that reliability refers to the trustworthiness of data, whereas validity refers to the trustworthiness of interpretation.

### **2.3.2.1 Reliability of interview analysis**

**Disclosure of orientation and social context** is seen as a necessary requirement of the reliability of qualitative research since the researcher is not seen as an objective figure in the analysis, but rather as an integral element of the data collected and analysed (Reason, 1981). The researcher’s beliefs, expectations and theoretical commitments will necessarily shape the emerging picture and, in order for readers to be able to judge the analysis, the researchers’ views need to be explained (Rennie et al., 1988). The implicit cultural assumptions relating to the circumstances under which the data was gathered also need to be made explicit.

The literature provided a starting point for this study, in particular the view that individuals with a history of CSA are more likely than non-abused client to have interpersonal problems and greater difficulty forming a successful therapeutic alliance. The study seeks to understand the therapeutic alliance based on Bordin’s pantheoretical model of alliance. Whilst the sample of clients were recruited from therapists who use a variety of therapeutic approaches, it is important to acknowledge the cognitive-

behavioural orientation of the author. The clients recruited were all individuals receiving therapy under the NHS and could thus be viewed to some extent as patients with particular problems to overcome. Clients who took part in the study were those who had successfully engaged in therapy and thus likely to provide positive comments.

**Immersion in the data**, through repeated encounters with the text and engagement with the data, is considered a form of reliability (Stiles, 1993). This study was designed to facilitate exhaustive cataloguing of the text and involves three stages of reading the original transcripts and repeated analysis of the codes to identify categories and links between categories.

**Confirmability or progressive subjectivity** refers to the openness of the research process and the extent to which data collection and analysis can be scrutinised (Stiles, 1993). To enhance confirmability, a research diary was kept to document decisions during the research and also to document some of the author's thoughts during the data collection and analysis process. A summary of the diary and samples of the data categories are reproduced in the appendices. The interview transcripts are also available from the author.

**Inter-rater reliability** provides a means of establishing whether categories are used in a standardised way so that different researchers categorise the interview data in the same way (Silverman, 1993). A quarter of the original transcripts were coded by an independent rater and compared with the coding completed by the author. This is reported in the results section.

### **2.3.2.1 Validity of interview analysis**

**Testimonial validity or credibility** refers to whether the participant is asked to check the accuracy of the interpretation. This can be difficult to implement as a power differential between researchers and participants may make the participants likely to agree with the account presented. Active searching for disconfirming evidence may promote greater rigour (Morrow & Smith, 1995). A third of the participants were sent the transcript of their interviews to check for accuracy and a third of the participants in the CSA group were invited to meet with the author to discuss the results during the final stages of the analysis.

**Coherence** refers to the quality of the interpretation itself, such as whether is it consistent and comprehensive and whether the account is grounded in the data (Stiles, 1993). Whether the interpretation has these qualities requires a decision by the reader. The account uses quotations from the original transcripts as a way of demonstrating that it is grounded in the data.

**Transferability and external validity** can be considered in terms of the degree to which the findings compare with those of other research. The report of the study should be detailed enough to allow such comparisons to be judged by the reader. The findings will be discussed in relation to other research in the discussion section.

**Reflexive validity and utility** refer to how theory is changed by the data and the extent to which the study produces an account that generates further research questions and ideas for further study (Stiles, 1993). These points will be covered in the discussion



section. The study will also provide information that can be used in the setting where the research was carried out.

### **2.3.3 Problem checklist**

A brief checklist was developed from the routine data form used by one of the psychology departments, shown in Appendix 6.3. With the permission of the participants, this was given to their therapist. It asks the therapist to identify the client's main problem and whether the client has disclosed a history of CSA.

## **2.4 Procedure**

### **2.4.1 Ethical approval**

Full ethical approval for this research was received from the Research Ethics Committees in the two districts where the research was carried out. Copies of the letters giving approval are shown in Appendix 6.4.

### **2.4.2 Pilot study**

Clients were asked by their therapists whether they were interested in taking part in the pilot study, and given the study information sheet and reply slip with a stamped addressed envelope (Appendix 6.5). Clients who returned the reply slip were telephoned and the study was discussed with them. If they agreed to participate, a meeting was arranged during which they were asked to sign a consent form, complete the questionnaires and take part in the interview.

### **2.4.3 Main study recruitment**

Therapists gave potential participants information about the study. This included a brief verbal description of the study and the written information sheet with reply slip and stamped addressed envelope. Clients either returned the reply slip indicating they were interested in finding out more about the study, or gave permission to their therapist to pass their details to the researcher. Potential participants were then telephoned and the study discussed with them, giving the opportunity to ask questions. A meeting was then arranged with those clients who agreed to take part.

Interested clients who did not want to be telephoned at home were sent information about the study by post and asked to reply indicating when they were be able to attend an interview.

### **2.4.4 Interview and data collection**

The meeting was either held at the participant's home or at the place where they attended therapy. It took between 30 minutes and one hour to complete. At the beginning of the interview, all participants were given the opportunity to discuss the study and ask questions. They were advised that they could stop at any time and did not have to answer any questions they were not comfortable with. They were also reminded that the information given was confidential and would be anonymised in the data analysis. They were asked to complete a consent form (Appendix 6.6) and for their verbal permission for a blank copy of the Client-Therapist Ratings Scale and the Problem Checklist to be sent to their therapist.

Participants were then given the questionnaires to complete. The researcher read out the questions for participants who had difficulty reading the questionnaires, and clarified any questions the participant was unsure of. The second half of the meeting consisted of the audio-taped semi-structured interview. Afterwards the participant was offered the opportunity to debrief and a debriefing information sheet with details of self-help books and help-lines was available (Appendix 6.7). The Client-Therapist Ratings Scale and the Problem Checklist were then sent to the therapist to complete.

## **2.5 Data analysis**

### **2.5.1 Quantitative analysis**

Analysis of the data was carried out using SPSS for Windows version 6 (Norusis, 1993). The size of the sample, type of information collected and the normality of the data governed the choice of statistical tests.

A descriptive analysis of the sample was carried out providing demographic information. Overall differences between the CSA and non-CSA clients on the measures of therapeutic alliance were analysed using T-Tests. Differences between the two groups on the IIP-32 were investigated using Mann Whitney Tests. Further analysis using ANOVA was carried out to investigate the effect of other factors, such as previous psychiatric or psychological treatment and length of therapy, on the group comparisons. Correlation analysis was performed to study the relationship between the scores of therapeutic alliance and interpersonal problems. The Wilcoxon Matched Pairs Test was used to compare therapist and client ratings of the alliance.



### **2.5.2 Qualitative analysis**

A second rater coded a quarter of the interviews, and inter-rater reliability was checked in two ways. Firstly, percentage agreement between the two raters was calculated for the number of interviews coded with each code. Secondly, agreement in the coding of each of the six main categories was tested using the Wilcoxon Matched Pairs Test.

The interviews were then analysed based on the principles of grounded theory. In grounded theory data collection and analysis are not separate stages, as categories and themes emerge from the data, further data is collected to extend the theory (Pidgeon & Henwood, 1996). This can be done by re-interviewing participants or extending the data collection to additional participants. In this study the latter approach was adopted.

The interviews were transcribed and then analysed in a number of stages following the guidelines of Pidgeon & Henwood (1996). Firstly, the transcripts were read and the paragraphs numbered. Sentences and phrases relating to the therapeutic alliance were highlighted and labelled with a code that described the meaning of the phrase. An indexing system was constructed by assigning each code to its own card and the specific transcript or phrase relating to that code copied onto it. Examples of the cards are shown in Appendix 6.8. The transcripts were read and coded throughout the data collection phase, using existing codes and by creating new codes. Codes were therefore generated from the data and then used to code subsequent interviews. These were revised by merging and splitting codes and recorded in the research diary, shown in Appendix 6.9.

Process links were then identified between the different codes and the cards were sorted into categories on the basis of similarities in meaning or concepts, shown in Appendix 10. The themes that emerged and the inter-relationships between categories were then considered in terms of existing theories.

### **3. RESULTS**

#### **3.1 Descriptive analysis**

##### **3.1.1 Demographic information**

The characteristics of the sample are shown in Table 1. A total of 34 women were interviewed, 17 of whom had disclosed a history of childhood sexual abuse, and 17 of whom had not. The age of the participants ranged from 21 to 63 years and a T-Test revealed that there was no significant difference between the mean ages of the groups.

Three quarters of the women in the non-CSA group were married, and the remaining quarter were single. Slightly more of the CSA group were single and two were divorced. Twice as many of the non-CSA women than the CSA women lived just with their partner, whilst a slightly higher proportion of the CSA women lived in a household including children. One woman in each group lived with friends, and two of the CSA and three of the non-CSA women lived alone. Two of the women in the CSA group lived with their parents.

Over half of the women worked either full or part-time, and a further six percent of CSA clients and 18 percent of non-CSA clients described themselves as housewives. Three

of the CSA clients compared to one of the non-CSA clients were on long-term sick leave, and the remainder were students or unemployed.

**Table 1. Demographic characteristics of the sample**

	CSA group		Non-CSA group	
<b>Age</b>				
Mean (years)	35.8		36.6	
SD	8.9		10.0	
Range	21 - 52		21 - 63	
<b>Marital status</b>	n	%	n	%
Single	5	29.4	4	23.5
Married/Cohabiting	10	58.8	13	76.5
Divorced/Widowed	2	11.8	0	0.0
<b>Living arrangements</b>				
Alone	2	11.8	3	17.6
Partner	3	17.6	6	35.3
Family	9	52.9	7	41.2
Parents	2	11.8	0	0.0
Sharing	1	5.9	1	5.9
<b>Employment status</b>				
Full-time	5	29.4	5	29.4
Part-time	4	23.5	5	29.4
Unemployed	0	0.0	1	5.9
Housewife	1	5.9	3	17.6
Student	4	23.5	2	11.8
Long-term sick	3	17.7	1	5.9
<b>Previous Psychiatric treatment</b>	12	70.6	6	35.3
<b>Previous Psychological treatment</b>	7	41.2	6	35.3

Almost two thirds of the CSA group has received previous psychiatric treatment compared with just over a third of the non-CSA group. There was less difference in the proportions of clients who had previously received psychological treatment, with over a third of both groups reporting previous psychological therapy.



3.1.2 Details of therapy

Thirty of the participants were receiving therapy from a psychologist working in two CBT dominated psychology departments or associated CMHT's. The remaining four participants were receiving therapy from psychotherapists working in a psychotherapy department.

Participants were being seen for a range of problems, shown in Table 2. Therapists ticked the 'other' category on the Problem Checklist for nearly half of the CSA clients. In the space to specify what 'other' meant, most of the therapists added that their client had a mixed presentation of problems, which some described as "CSA-related difficulties". Although participants in the second group were recruited from people referred for anxiety-related problems, a range of other types of difficulties were identified by the therapist as the main focus of therapy for nearly half of this group.

Table 2. Details of therapy

	CSA group		Non-CSA group	
Main problem	n	%	n	%
Anxiety <sup>1</sup>	1	5.9	9	52.9
Depression	3	17.6	4	23.5
Obsessional disorder	1	5.9	1	5.9
Relationship problems	1	5.9	1	5.9
Anger problems	1	5.9	0	0.0
Post traumatic stress disorder	1	5.9	2	11.8
Psychotic symptoms	1	5.9	0	0.0
Other	8	47.0	0	0.0
Length of treatment				
Up to 10 sessions	4	23.5	8	47.1
11-20 sessions	4	23.5	4	23.5
Over 20 sessions	9	53.0	5	29.4

<sup>1</sup> includes general and health anxiety, panic disorder and phobias

Clients in the CSA group tended to have completed more sessions of therapy, with just over half reporting over 20 sessions, compared with just under a third of the non-CSA group. Nearly half of the non-CSA groups had received 10 sessions or fewer compared to less than a quarter of the CSA group.

### 3.2 Hypothesis 1

*Clients who were sexually abused during childhood will have lower scores of therapeutic alliance than non-abused clients.*

**Table 3. Mean scores of therapeutic alliance**

	CSA group		Non-CSA group	
	n =17		n =17	
WAI	Mean	SD	Mean	SD
Total score*	6.0	0.56	6.4	0.43
Goals	6.1	0.54	6.4	0.55
Tasks	6.0	0.68	6.3	0.67
Bonds	5.9	0.77	6.2	0.68
HAq-II				
Total score	5.4	0.43	5.5	0.37
Positive alliance	5.4	0.43	5.5	0.37
Negative alliance	5.3	0.78	5.3	0.66
Progress	5.6	0.66	5.8	0.36

\* p<0.05

Table 3 shows that total scores on the WAI were significantly lower for the women in the CSA group compared to the non-CSA group ( $t(32) = -2.292, p < 0.05$ , one-tailed). The CSA group also had lower average scores on all three of the sub-scales, although not significantly lower. The task sub-scale scores were close to being significantly different ( $t(32) = -1.654, p = 0.054$ , one-tailed). The scores for the CSA group were not significantly greater than those of the non-CSA group on the HAq-II. Results from

ANOVAs showed that previous psychiatric and psychological treatment and length of therapy had no significant effect on the differences between the two groups.

### 3.3 Hypothesis 2

*Clients who were sexually abused during childhood will report more interpersonal problems than non-abused clients.*

**Table 4. Mean scores on IIP-32**

	CSA group		Non-CSA group	
	n = 17		n = 17	
IIP-32	Mean	SD	Mean	SD
Total score	1.6	0.54	1.5	0.55
Hard to be sociable	1.6	0.86	1.5	0.89
Hard to be assertive	1.5	1.14	2.0	1.37
Too aggressive*	1.5	1.02	0.9	0.79
Too open	1.2	1.10	1.6	1.15
Too caring	2.2	1.25	2.3	1.17
Hard to be supportive	1.1	1.08	0.5	0.52
Hard to be involved	1.6	1.30	1.1	0.72
Too dependent	1.6	0.81	1.8	0.92

\*  $p < 0.05$

The CSA group did not score significantly higher on the total score of the IIP-32, shown in Table 4. There was a significant difference on one of the sub-scales, with the CSA group scoring higher on 'too aggressive' ( $U = 88.5$ ,  $p < 0.05$ , one-tailed). The CSA group also scored higher on 'hard to be involved' and 'hard to be supportive', however, these differences were not significant.



### 3.4 Hypothesis 3

*Scores on the measures of therapeutic alliance will be inversely correlated with scores on the measure of interpersonal problems.*

A significant negative correlation was found between the total scores on the WAI and IIP-32, shown in Table 5, but not between the HAq-II and the IIP-32. This significant correlation was found only for the CSA group when correlations were performed on the two groups separately. The WAI and HAq-II showed a significant positive correlation, however this was only found for the non-CSA group in the separate group analyses.

**Table 5. Pearson correlations between measures**

Measures		WAI	HAq-II
Total sample	IIP-32	$r = -0.468^{**}$	$r = -0.141$
	HAq-II	$r = 0.533^{**}$	
CSA group	IIP-32	$r = -0.811^{**}$	$r = -0.287$
	HAq-II	$r = 0.348$	
Non-CSA group	IIP-32	$r = -0.009$	$r = 0.061$
	HAq-II	$r = 0.786^{**}$	

**\*\*  $p < 0.01$**

### 3.5 Hypothesis 4

*Clients and therapists will differ in their rating of therapeutic alliance factors for both abused and non-abused clients.*

Using the Wilcoxon Signed Ranks Test, highly significant differences were found between client and therapist ratings on all of the five questions on the Client-Therapist Ratings Scale and on an aggregate score. Clients were shown to score significantly

higher than their therapist in both the CSA and non-CSA groups.

**Table 6. Wilcoxon Signed Ranks Test of Client-Therapist Ratings Scale**

	CSA group	Non-CSA group	Total clients
<b>Client-therapist ratings</b>			
Total score	$z = -3.520^{**}$	$z = -3.628^{**}$	$z = -5.018^{**}$
Agreement of goals	$z = -3.201^{**}$	$z = -3.256^{**}$	$z = -4.521^{**}$
Agreement of tasks	$z = -3.431^{**}$	$z = -3.384^{**}$	$z = -4.763^{**}$
Bond	$z = -2.676^{**}$	$z = -2.803^{**}$	$z = -3.874^{**}$
Provided help needed	$z = -3.650^{**}$	$z = -3.580^{**}$	$z = -5.067^{**}$
Worked well	$z = -3.213^{**}$	$z = -3.086^{**}$	$z = -4.446^{**}$

**\*\***  $p < 0.01$

### 3.6 Hypothesis 5

*The two groups of participants will generate different accounts using qualitative analysis.*

#### 3.6.1 Reliability and validity of the analysis

The first rater, the author, created the coding categories during the process of coding the transcripts. These were merged and refined to a final list of 34 codes. This number is within the range of categories quoted in other research, such as between 27 and 115 categories (Clegg, Standen & Jones, 1996; Mason, 1994). The final list was then given to a second rater who used these to code a quarter of both the CSA and non-CSA group interviews.

Table 7 shows that there was at least 62.5 percent agreement for 91.2 percent of the codes. However, three of the codes had inter-rater agreement of 50 percent or less. These included professionalism, being honest and genuine, and a close connection or

collaboration. Wilcoxon Matched Pairs Tests showed that there were no significant differences between the two raters on the coding of the six main categories that emerged in the grounded theory analysis.

**Table 7. Inter-rater reliability of interview coding**

Agreement between raters	Number of codes	Cumulative percentage
100 %	4	11.8
87.5 %	8	35.3
75 %	9	61.8
62.5 %	10	91.2
50 %	2	97.1
37.5 %	1	100.0

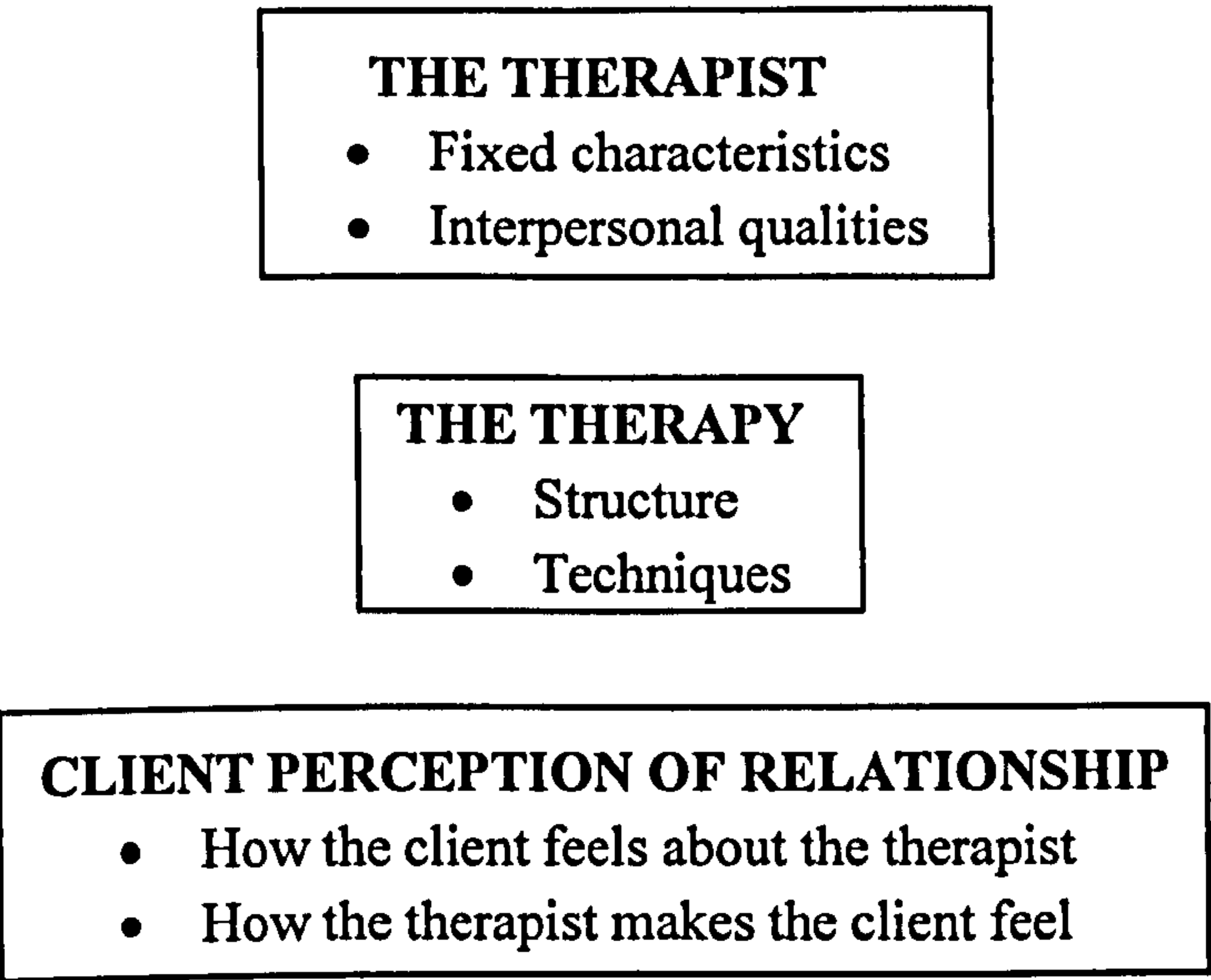
To establish testimonial validity the typed transcripts were sent to a third of the participants after the interview, for them to check and comment on. None of the interviewees requested any alterations to their interviews. A summary of the findings was discussed with two of the CSA participants and their comments incorporated into the final analysis.

**3.6.2 The grounded theory account of the interview data**

The following account reflects the responses of women who have disclosed a history of CSA compared with those who have not, about what was important to them in their relationship with their therapist. Three main themes emerged from the data, each of which were divided into two sub-themes. The women interviewed described characteristics of the therapist, factors relating to the therapy itself, and the clients' perceptions of the therapeutic relationship. This is shown in Figure 1 and discussed in the following section.



**Figure 1: Themes from the qualitative interviews**



**3.6.2.1 The therapist**

**Table 8: Coding categories relating to the therapist**

<b>Fixed characteristics of therapist</b>	<b>Interpersonal qualities of therapist</b>
Age	Personality
Gender	Professionalism and competence
Training and education	Soft and gentle pace
	Honesty and genuineness
	Care, encouragement and reassurance
	Listens
	No alarm or negative reaction
	Sensitivity and responsiveness
	Humour

The first theme that emerged from the data was ‘the therapist’. This included factors that could be described as fixed characteristics of the therapist that define who they are, such as age and gender. It also included factors relating to the way the therapist interacted with their client, or broadly referred to as interpersonal factors. These are shown in Table 8. These factors were often described as particularly important in the initial sessions, for example one women said ‘he was very friendly right from the start,

as soon as we met, the first couple of sessions, you could see that he was interested in helping you in what was going on’.

#### **(i) Fixed characteristics of the therapist**

This category of factors generated more comments from the CSA group than the non-CSA group. Age was mentioned by six (35%) of the women in the CSA group compared to five (29%) of the non-CSA women. Most comments suggested that the therapist’s age was beneficial to the therapeutic relationship either because the therapist was about the same age as the client or the client saw their therapist as a ‘mother’ or ‘father’ figure, although one CSA woman did comment of her therapist ‘she’s a lot younger than I am and that did bother me at one time’. Eight (47%) of the CSA group mentioned gender, compared to three (21%) of the non-CSA group. Six of the CSA clients said that they found it easier having a female therapist, and two women commented that they were either ‘a bit unsure’ of a male therapist or it ‘took a while to settle down because he was a man’. In contrast, the three women in the non-CSA group who mentioned gender had a more mixed response. Different women preferred a woman, preferred a man, or had no preference. Both groups of women viewed their therapist’s training and education positively, with comments from six (35%) women from both groups.

#### **(ii) Interpersonal qualities of the therapist**

The range of therapist interpersonal qualities fell into nine main categories. The most commonly mentioned were personality and professionalism. Personality was mentioned by more of the CSA clients, 13 (76%), than non-CSA clients, 10 (59%), and included

the therapist being approachable, friendly, calm, nice, warm and relaxed. Professionalism was also mentioned by 13 (76%) of the CSA clients, and a smaller proportion of non-CSA clients, 10 (59%). It was discussed in terms of a professional manner, competency and ability to help the client, although non-CSA clients tended to stress the latter element.

A soft and gentle pace was mentioned by 11 (65%) of the CSA clients, and 10 (59%) of the other clients. One CSA woman said 'she never pushes me, another said 'she gives space to be able to think', and another 'we go gradually'. Nine (53%) of the CSA clients described their therapists as being honest or genuine, compared with only five (29%) of the non-CSA group.

In the category of care and encouragement, mentioned by eight (47%) of the CSA clients and seven (41%) of the non-CSA clients, the non-CSA group spoke more of feeling encouraged, whilst the women in the CSA group commented more that their therapist cared or gave reassurance. For example one woman said:

'Possibly what has been the most helpful is to believe or to be reassured that yes, there are modifications to your behaviour. I say things to her like when is this all going to stop and she says to me it will stop, we will get there'.

Seven (41%) clients in the CSA group, and five (29%) in the non-CSA group, said they felt that the therapist listened to them. In addition, seven (41%) clients in the CSA group commented on the importance of their therapist not showing alarm, horror or disgust, or that 'she never pulls a funny face' in response to things that the client talked



about. The other client group never mentioned this point.

Six (35%) of the CSA women, and 10 (59%) of the non-CSA women, commented on their therapist being sensitive and responsive. This is illustrated by comments from two of the CSA women, ‘her body language, being so sensitive’, and ‘she always says the right things’. The final quality mentioned was humour, which was raised by five (29%) of the women in the CSA group and six (35%) of the other group.

**3.6.2.2 The therapy**

The second theme that emerged from the data related to the therapy itself. This was divided into structural factors of therapy and techniques of therapy, shown in Table 9, and some of these appeared to become more prominent as therapy progressed.

**Table 9: Coding categories relating to the therapy**

<b>Structural aspects of therapy</b>	<b>Techniques of therapy</b>
Boundaries	Giving different perspectives
Commitment	Advice, practical or points of fact
Structure and focus	Confidence building
Confidentiality	Helping find own answers or words
Environment and begin/end of sessions	Recapping and remembering

**(i) Structural characteristics of therapy**

Participants spoke of a range of factors that were structural in the way their therapy was carried out. The most frequently mentioned was boundaries, raised by 12 (71%) of both groups. CSA clients commented that they found boundaries about length of session, restriction on therapist disclosure and expectations of themselves and the therapist, all

helpful. Whilst four of the non-CSA clients said they liked the fact that their therapist did not share personal information, two others commented that they found disclosure reassuring. Two of the CSA interviewees voiced concern about what their therapist really thought of them. One woman commented:

‘She doesn’t show what her real views are, which is the only thing that sometimes worries me, because I always think that this is what she is saying but does she mean that’.

One of the CSA clients felt strongly about contact between sessions and said ‘my biggest beef is that it’s only contact once every 10 days. It’s like I will sit and listen to you and help you but only within the allotted time slot’. In contrast to the non-CSA clients, eight of the CSA clients (47%) commented that they found open-ended or long-term time limits in therapy helpful. This seemed to be related to the therapist’s commitment, raised by four of the CSA clients and none of the other clients. One woman said:

‘I committed myself and I wanted the same commitment. I needed to let her know that it wasn’t going to be quick.’

Structure and direction were mentioned by nine (53%) of the CSA clients and eight (47%) of non-CSA clients. Comments from the CSA clients ranged from ‘I need a solid structure’ to ‘there’s just a little bit of guidance leading me in the right direction’ to ‘she’s very good at leading you in a sense without leading you’.

Five (29%) of the clients in each group mentioned confidentiality. Confidentiality was described as a positive factor helping the client to talk openly to their therapist. The environment of therapy was raised by five (29%) of the CSA clients and two (12%) of the non-CSA clients. Two of the CSA clients said they found the physical environment where they attended therapy hostile, and one of these clients, plus another three of the CSA clients, commented that it was important how their therapist began and ended their sessions. For example, one woman said 'he'd never start off a session right let's get onto it' and another said 'I never felt there were things left hanging in the air'.

## **(ii) The techniques of therapy**

Both groups mentioned a range of techniques used by their therapist, which they felt had helped in the relationship they formed with their therapist.

Giving different perspective and alternative explanations was mentioned by 13 (76%) CSA and 10 (59%) non-CSA clients. This often took the form of a formulation that made sense of the client's difficulties or provided an explanation or education of ways of thinking and behaving, especially if this normalised the client's experience. For example:

'Just having someone to say this is the process that happens to you when you dissociate or whatever, this is what happens to you, this is natural, this is normal'.

Giving advice was mentioned by nine (53%) CSA and 10 (59%) non-CSA clients. Whilst the women in the non-CSA group mentioned practical suggestions such as diary



keeping and behavioural tasks, the women in the CSA group also mentioned that they found advice in the form of statements important. For example, one woman remembered being told ‘that shouldn’t have happened’ and another remembered her therapist saying ‘it wasn’t your fault’. A few women in the CSA group also mentioned being helped with specific things pertinent to them, such as evidence for taking their abuser to court or giving specific advice about child care.

In addition, four (24%) clients in both groups also mentioned confidence building. Four (24%) of the CSA and five (29%) of the non-CSA clients mentioned helping the client find their own answers or words. A greater number of CSA clients, five (29%), mentioned that their therapist remembered information from previous sessions compared with three (18%) of the non-CSA clients. For example, one woman in the CSA group commented ‘he remembers it all so I don’t have to tell things over and over again’.

### **3.6.2.3 Client perceptions of the relationship**

The third theme that emerged from the data related to client perceptions of the relationship they had with their therapist. This appeared to reflect that the relationship had developed over time from both the characteristics of the therapist and the therapy. As one woman said ‘I think the relationship is built and not made’. Two main categories emerged in the way interviewees described the relationship, shown in Table 10. Firstly, how the client felt about the therapist, and secondly, how the therapist made the client feel.

**Table 10: Categories related to client perceptions**

<b>How the client feels about the therapist</b>	<b>How the therapist makes the client feel</b>
Trust	Able to discuss difficult things
Respect	Accepted and non-judged
Close connect, collaboration, dependency	Working to own agenda and words
Friends	Comfortable, OK to cry
Worried about therapist's view of client	Understood
	Safe, secure and supported
	Important and valued

**(i) How the client feels about the therapist**

Women from both groups made comments that fell into the five coding categories, which made up the larger category of ‘how the client feels about the therapist’.

Ten (59%) of the CSA compared with five (29%) of the non-CSA group talked about trust. For example, comments by some of the CSA clients included ‘the fact that it was trust that I felt, I could trust him and talk to him’, and ‘getting to know each other, getting to trust, learning that she’s there to help me’. Respect was another factor that was mentioned by seven (41%) of the CSA women, compared to three (18%) of the non-CSA clients. One of the women in the CSA group said:

‘We held the same ground and I had respect for her and expected respect back, and I got it. Unless you respect somebody you can’t go back over things. I had to respect the person I was with.’

Whilst many of the participants commented on how the relationship with their therapist was different to their usual relationships, six (35%) of the women from the CSA group and 10 (59%) of the women in the non-CSA group did talk of a close connection and sense of collaboration. A few of the CSA clients commented ‘I just feel like he’s got

part of me', and 'she says I'm here, we're here together'. Four (24%) of the non-CSA clients and three (18%) of the CSA clients did talk about their relationship with their therapist as almost like 'friends'.

All of the people interviewed reported a positive relationship with their therapist, however, one (6%) of the non-CSA clients and three (18%) of the CSA clients did worry about how their therapist really viewed them or whether they tended to only see their problems. One woman in the CSA group said:

'I sort of think she doesn't know anything about my normalness. I'm self-conscious of sharing all my negative stuff.'

#### **(ii) How the therapist makes the client feel**

A final way that people discussed what was important in the therapeutic relationship was 'the way the therapist made them feel'. The categories that make up this sub-theme contained the greatest number of comments from those interviewed.

Being able to talk about difficult things was mentioned by 15 (88%) of the women in the CSA group and 11 (65%) of women in the non-CSA group. For the non-CSA group, women talked of a range of issues including discussing difficult subjects, feeling open enough to say 'exactly what you felt' and being able to say if the client was unhappy about something in therapy. Women in the CSA group covered similar areas, but also included talking about things that were upsetting or embarrassing, or things that they hadn't ever talked about before. One woman said:



‘I think I spoke to him about things, which I’ve never discussed with my husband or mum. Something I’ve not discussed with anyone before. There was a lot of things which I had in the background that I’d never spoken with anyone, like never spoken them until getting together with him. I think that really helped.’

Feeling accepted and not judged was mentioned by more of the CSA clients, 14 (82%), compared to the non-CSA clients, five (53%). Women in the CSA group said ‘she accepts you as you are’, ‘she wouldn’t say she disapproves, or show it’, ‘he didn’t ever judge me’ and ‘you never felt as if you were being stupid for being upset or getting angry’. None of the women in the non-CSA specifically mentioned being believed, although this was raised by five of the women in the CSA group. One woman said:

‘I like to think that she was the only one that believed me, when a lot of people didn’t believe me in the past, she really did’.

Thirteen (76%) of the CSA clients and 11 (65%) of the non-CSA client valued being able to follow their own agenda. This included being able to work in their own time, express things in their own words, and feeling that their therapist listened to what they wanted. One client expressed this as ‘if I was going to open the door then I had to open it in my own time’. Another client said ‘when we first met we discussed what the problems were and what I wanted to work on’. This raised the idea of flexibility, one woman expressed this as:

‘If I’ve got something I want to talk about which she hadn’t really planned on she’ll still talk about what I want to talk about even if it’s a different subject to

what we normally talk about.'

Feeling comfortable was also a frequent point raised by 12 (71%) of the CSA women and 8 (47%) of the others. Feeling comfortable enabled clients to be able to talk about what they wanted to talk about. People described that they seemed 'to click' with their therapist, or 'felt at home', or that being with their therapist 'felt natural'. For the CSA group especially it was important that they felt able to cry or be upset and that their therapist had allowed them to do that.

In forming a positive relationship, eight (47%) clients in the CSA group and nine (53%) in the non-CSA group mentioned the importance of being understood. One person expressed this as 'she tries to understand what you are talking about', another said 'she could relate and see where I was coming from'. Safety and security were raised in eight (47%) of the CSA interviews and seven (41%) of the other interviews. Finally, feeling valued and liked, for example that they were 'not just another patient' or that 'he likes me as a person', was mentioned by six (35%) of the CSA clients and four (24%) of the non-CSA clients.

## **4. DISCUSSION**

### **4.1 Aims of the study**

The study investigated the hypotheses that clients who had disclosed a history of CSA had lower scores of therapeutic alliance and higher scores of interpersonal problems compared with clients who had not disclosed abuse. Differences between clients and

therapists ratings of the alliance were investigated. The study also explored the factors that clients thought were important in the therapeutic alliance. Before discussing the findings of the study, and how they relate to the literature and clinical practice, some methodological issues will be discussed.

## **4.2 Methodological issues**

### **4.2.1 Design of the study**

The use of both quantitative and qualitative methods was useful in providing two different methodologies with which to explore the therapeutic alliance. Quantitative methods allowed specific hypotheses to be tested. Qualitative methods allowed exploration of the idiosyncrasies of each participant's interpersonal experiences. The choice of qualitative approaches was appropriate for the group of people studied because qualitative methods of data collection emphasise employing methods that are empowering for participants, which are particularly appropriate for research with vulnerable client groups, such as people with traumatic backgrounds who are seeking help.

### **4.2.2 Participants of the study**

The sample consisted entirely of women. This may reflect the fact that in the services sampled, it is women who predominantly seek therapy for difficulties relating to a history of abuse. There may also be a bias in the people who were approached and chosen to help with the study. For example, more women than men may have been approached. Information was not collected about clients who were eligible for the study but did not take part. It was therefore not possible to determine biases in the sample. It



is, however, likely that those clients who were approached by their therapist and agreed to take part in the study had good relationships with their therapists. The sample is therefore partly therapist selected and partly self selected by the participants.

It was not possible to match the two groups by individual therapists, although this would have been preferable in order to eliminate bias due to individual differences between therapists. Participants also varied in the number of sessions of therapy they had received, and although differences in the measurement of the therapeutic alliance over time have been shown to be fairly small (Horvath et al., 1993), this may account for some variation in the data. There were also some demographic differences between the two groups, such as more of the CSA group were on long-term sick leave and two of the CSA group were divorced compared with none of the non-CSA group.

Information on ethnic origin was not collected, although the majority of the participants, and the researcher, were white. This sample is, therefore, culturally biased towards white people. Participants were recruited from a clinical sample and therefore cannot be considered representative of the general population.

#### **4.2.3 Definitions**

The definition of CSA was very broad to intentionally include a wide range of different types of abuse histories, which may have resulted in a wide variety in the experience of the participants. Participants were not interviewed to determine whether they fulfilled the definition but rather their therapist was asked whether they had disclosed information that fulfilled the definition. This is not a rigorous method of establishing

previous history, and as a result clients who have experienced abuse but not disclosed it, may have been included in the non-CSA group. The possibility also exists that some clients in the CSA group may have misreported their past and thus be erroneously included in the CSA group. Briere (1992) says that in retrospective studies the accuracy of sexual abuse reports cannot be assured, in terms of ruling out either false positive or false negatives without using methods to verify reports with corroborating evidence. This was not possible within the constraints of this project and was considered unnecessarily distressing for the participants.

The study did not require therapists to use strict diagnostic criteria, such as DSM IV (1994), to identify the problem of the client. This would have given a more accurate description of the client's difficulties, but would have placed an additional demand on the therapist. This was considered unnecessary because the clients' presenting problems were not the focus of the study.

#### **4.2.4 Measures and data analysis**

Two separate standardised measures of the therapeutic alliance were used, along with a non-standardised measure. Although not subject to validity and reliability tests, this latter scale provided a quick and easy questionnaire to complete to maximise therapist compliance. Existing therapist questionnaires have been shown to be lengthy and less effective than the client versions in measuring alliance (Horvath & Symonds, 1991).

Recruiting a larger number of participants would have increased the power of the statistical analysis. Non-significant differences between the two groups may then have

proved to be significant. However, the lack of significance could also have reflected that the differences between the two groups were in reality small and mainly attributable to chance.

#### **4.2.5 The 'trustworthiness' of the qualitative interviews**

The account provided by the qualitative interview aimed to be a valid account of the experiences of the two groups rather than a reliable account generalisable to others engaged in therapy. Grounded theory analyses are typically conducted on small samples, which limits the extent to which findings can be generalised to wider groups of people. Grounded theory does, however, provide the generation of theory directly related to the real experiences of the individuals studied, which can then be explored with other groups of people (Rennie, Phillips & Quartaro, 1988).

The reliability of the qualitative analysis was checked in a number of ways, previously described in the method section. The inter-rater reliability checks demonstrated a reasonable level of agreement between the two raters in the coding of the interviews. There were some differences between the raters, which reflects the subjectivity that is inherent in coding transcript data which leads to the same statement being interpreted in different ways by different raters. Also, the second rater did not have the contextual factors available to the first, such as the interviewee's gestures and emphasis of speech.

Whilst the grounded theory analysis may have demonstrated reliability, this does not mean that the same categorisations and account would have been obtained by different researchers (Frontman & Kunkel, 1994). Other researchers would bring with them



different ideas and expectations, which would influence the outcome of the analysis. However, by documenting the analytic process the researcher enables readers to judge the researcher's decisions for themselves.

The interview transcripts were given back to a third of the interviewees to give testimonial validity to the analysis. Unfortunately, due to time restraints, the results were only discussed with two of the participants. Ideally this would have been done with a larger number of participants. Readers must decide for themselves the extent to which the grounded theory provides a credible and coherent account which has any "rhetorical power" in describing the therapeutic alliance. The transferability and utility of the study will be discussed in terms of how the findings compare with existing research and clinical practice.

The two types of data collected in this study were not used as a method of triangulation because the different methods were designed to address different questions and not to check the validity of each other. However, the use of two different methodologies can be viewed as enhancing the validity of the overall analysis by providing a more rounded overall picture (Mason, 1994).

### **4.3 Summary of findings**

A summary of the results will be presented and discussed in terms of each of the hypotheses. Further discussion of the interpretation and implications of the findings will follow.

#### **4.3.1 Hypothesis 1**

The hypothesis that CSA clients will have significantly lower therapeutic alliance scores than non-CSA clients was demonstrated in the comparison of the two groups on total scores of the WAI, but not the HAq-II. The CSA group also had lower scores on all three sub-scales of the WAI, although not significantly lower. These findings support previous findings that CSA clients may have more difficulty forming a positive therapeutic alliance compared to non-abused clients (Alpher & France, 1993).

#### **4.3.2 Hypothesis 2**

There was no significant difference in the total IIP-32 scores between the two groups, which did not support the hypothesis the CSA clients have more interpersonal problems than other clients.

The CSA group did score significantly higher than the non-CSA group on one of the sub-scales of the IIP-32, 'too aggressive'. The CSA group also showed higher scores than the non-CSA group for the sub-scales 'hard to be involved' and 'hard to be supportive', although not significantly higher.

#### **4.3.3 Hypothesis 3**

A significant negative correlation was shown between the WAI and IIP-32, suggesting that lower scores on the therapeutic alliance were associated with higher levels of interpersonal difficulties. More detailed analysis revealed that this correlation was found only for the CSA group and not the non-CSA group. These findings provide some confirmation of previous findings that clients with a wide range of interpersonal

problems report a poorer quality therapeutic alliance (Mallinckrodt et al., 1995; Marziali, 1984; Muran et al., 1994; Piper et al., 1991).

A similar significant correlation was not found between the HAq-II and the IIP-32. Although there was a significant correlation between the WAI and HAq-II, this was found to be for the non-CSA group alone, and not for the CSA group.

#### **4.3.4 Hypothesis 4**

Highly significant differences were found between clients and therapists on the aggregate and individual scores of the Client-Therapist Ratings Scale, for both groups of clients and for the total group of participants. On all scores, clients gave higher ratings than therapists, which is consistent with the previous findings that therapists tend to rate the therapeutic relationship more negatively than clients (Bachelor, 1991; Marziali, 1984).

#### **4.3.5 Hypothesis 5**

There was a high level of agreement in the range of factors mentioned as being important in the therapeutic relationship by both groups of clients. However, the two groups did differ in the emphasis and importance they placed on the different factors. In general, the CSA participants tended to talk more about the interpersonal qualities of the therapist and how they felt about their relationship with their therapist. In contrast, the other clients talked more about the therapeutic techniques and the progress they were making in therapy. Three main themes emerged from the data, therapist factors, therapy factors and client perceptions, each of which were divided into two main categories.



Among the therapist factors, CSA participants tended to place more emphasis than the non-CSA participants on 'who the therapist was as a person', such as their age and gender, and 'the way that they acted', such as their personality and whether they were professional, honest and genuine. Women in both groups commented that it was important that their therapist listened, cared and acted in a gentle and sensitive way. Only the CSA clients mentioned that it was important that their therapist did not show negative reactions to things that the client talked about.

When discussing the therapy itself, women in the CSA group generated more comments on the importance of the structural aspects of therapy, such as confidentiality and the physical environment of the therapy. In particular, the commitment of their therapist and open-ended or long-term duration of therapy was important. One woman said 'I've seen her a lot more than I expected, but that's probably good because you need time to work'. There were mixed feelings about the boundaries of therapy in both groups of clients, with varying opinions about whether disclosure by the therapist was helpful or unhelpful.

There was a high agreement in the kinds of therapeutic techniques mentioned by both groups. The techniques of 'giving advice or practical suggestions' and 'sharing different perspectives' were the two most commonly mentioned by both groups. The CSA clients made more comments about the importance of factual statements made by their therapist that seemed pertinent to them. One woman said 'I remember her saying to me that you can't make a pervert, I suddenly thought it was not my fault. I could allow myself to think it wasn't your fault'. Both groups mentioned confidence building,

helping the client find their own answers, and particularly for the CSA group, recapping information talked about in previous sessions.

The two groups of clients differed when they talked about their perception of their relationships with their therapist. Many more CSA clients mentioned trust and respect, whereas the non-CSA clients more often described the relationship in terms of friendship or a close connection. More of the CSA clients worried about what their therapist 'really' thought of them.

The final category, 'how the therapist made the client feel', generated the most comments. The two groups raised a similar range of factors, although the CSA group talked more about them. In particular, more of the CSA women commented that it was important that they felt able to talk about things that were upsetting or embarrassing, that they felt able to be upset and cry, and that they weren't judged by their therapist, or that 'she accepts you as you are'. Only women in the CSA group raised the issue of being believed.

#### **4.4 Interpretation of findings**

##### **4.4.1 Therapeutic alliance**

The results from the quantitative analysis showed that, based on one measure of therapeutic alliance, the women interviewed who had a history of CSA had lower overall scores of therapeutic alliance compared with non-CSA women. The overall level of alliance was, however, high for both groups.

The sub-scale scores of the WAI suggested that the two groups may have differed more on the task sub-scale compared to the goal and bond sub-scales. This difference was not significant, perhaps due to the small sample size, but suggests that CSA and non-CSA clients may differ more on the tasks of therapy than the goals of therapy and therapeutic bond.

Although both the WAI and the HAQ-II are based on Bordin's (1979) pantheoretical perspective, the WAI has been found to place more emphasis on the tasks and goals of therapy, whereas the HAQ-II concentrates more on the third element of the model, the therapeutic bond (Hatcher et al., 1995). The difference between the results for the two scales suggests that the WAI may have been more sensitive in detecting differences between the two groups because the two groups differed more on the tasks of therapy than on the goals or therapeutic bond. Although length of therapy was not found to significantly influence the difference between the two groups, the fact that the CSA group tended to have longer therapy may have influenced the scores on the sub-scales.

#### **4.4.2 Interpersonal problems**

The lack of difference between the two groups on the total levels of interpersonal problems may reflect the small sample size, but it may equally suggest that the difference between the two groups was small. The CSA group had significantly higher scores on the sub-scale 'too aggressive', which suggests that survivors of CSA may be confrontational with other people than the non-CSA group.

The results from the correlations suggest that the inverse relationship between alliance



and interpersonal problems was only present for the CSA group. Levels of interpersonal difficulties did not predict alliance for the non-CSA group. This may reflect a difference in the types of interpersonal difficulties experienced between the two groups. The areas that women in the CSA group were more likely to experience difficulties in, may have more influence on the therapeutic alliance than the areas that the women in the non-CSA group had more difficulties in. The non-significant differences on the IIP-32 may be suggestive of this as the CSA group scores higher on 'hard to be involved' and 'hard to be supportive', whereas the non-CSA group scores higher on 'hard to be assertive'. Previous research has demonstrated that friendly-submissive interpersonal problems, such as difficulty being assertive, were positively related to development of the alliance, whilst hostile-dominant interpersonal problems were negatively related to alliance (Muran et al., 1994). It may be the particular type of interpersonal difficulty that is relevant to the quality of the therapeutic alliance, rather than a general elevated level of interpersonal problems.

#### **4.4.3 Client – therapist differences**

The scale used to compare client and therapist ratings is not a standardised measure and therefore the results need to be considered cautiously. Previous research has reported that therapists tend to give higher ratings to the goals and tasks of therapy, whereas clients favour therapist warmth and helpfulness. (Bachelor, 1991). Similar differences were not observed in this study, which may partly be the result of the brevity of the scale used, and partly due to the generally high level of ratings given by clients to all five questions.

These findings do, however, lend support to the finding of previous studies that clients and therapists differ in their ratings of the alliance, with clients generally rating the alliance more positively (Marziali, 1984). This is an important observation given that client perceptions have been found to be better predictions of outcome (Luborsky, 1986).

#### **4.4.4 Alliance themes**

The literature on working with survivors of abuse emphasises thematic issues such as trust, safety and intimacy (Crowder, 1995; Jehu, 1994). This was also reflected in the responses from the interviews conducted for this study. More women in the CSA group mentioned trust, and also placed more emphasis on the integrity of their therapist, such as whether they were honest, genuine, open and professional. Other research has found that client's who have experienced sexual assault emphasise the importance of their therapist being warm, trustworthy, non-judgmental and empowering (Draucker, 1999). These interpersonal themes can be seen to run through all three of the main themes that emerged in the grounded theory account, the therapist, therapy and client perceptions.

Many of the issues raised related to three of the dynamics described in the traumagenic dynamics model (Finkelhor & Browne, 1985). Participants talked of a range of factors that could be viewed as relating to the dynamic of betrayal. They stressed the importance of trust, commitment of the therapist, feeling comfortable and able to be upset, and feeling safe and supported. Confidentiality also seemed to relate to this. For example one woman said:

‘Knowing that it’s completely confidential and that nothing is going to get back to anyone else, that side of it would make people open up a lot more, knowing



that they can talk and they're not going to be discussed about five minutes down the road.'

Other comments related more to the dynamic of powerlessness, for example, some of the women reported that it was important that they felt important and valued and that they focused on what was important to them in therapy. One woman said:

'If I didn't want to say something I didn't have to put up a fight or anything, I could say what I wanted to say and if I didn't want to say or write anything, we didn't.'

Comments relating to stigmatisation referred to being believed, concern about the way the therapist 'really' viewed them and being able to talk about their abuse without receiving a negative reaction. One woman stressed how important it was that 'she doesn't ever get alarmed, she never shows horror or disgust'.

Cognitive models have not proposed particular patterns of beliefs and thought processes specific to survivors of CSA. Rather they have proposed a general model suggesting that individuals develop specific interpersonal schemas as result of their interpersonal experience. Many of the comments made by women in this study could be interpreted as suggesting the presence of particular interpersonal schemas, which then influence the therapeutic relationship. Three have already been discussed, betrayal, powerlessness and stigmatisation. Young (1990) suggests other schemas such as abandonment, mistrust, social isolation, dependence and shame/embarrassment, which may be related to some of the factors raised in this study.



Only two of the coding categories contained comments solely from the CSA clients. The first was that of the therapist's commitment to therapy, which was often talked about when discussing boundaries of the duration of therapy. One woman said 'what could have been sorted out at the start was being committed to me, that she's with you for as long as you need'. This reflected the strength of feeling and commitment that the client felt they were investing in entering therapy, and perhaps also fears about the outcome of therapy. This may have been an accurate perception on the client's part, that short-term therapy would not meet their needs. Alternatively, it may have reflected particular interpersonal schemas relating to fears of being discarded by the therapist.

The second category unique to the CSA groups was that the therapist didn't show a negative reaction such as shock or disgust at things the client talked about. This could suggest underlying beliefs relating to stigmatisation, but it could also suggest other interpersonal beliefs such as the effect that hearing about the client's experiences would have on the therapist, or about possible negative consequences that might result from discussing distressing material.

#### **4.4.5 Development of alliance**

The group of comments that emerged, that hadn't been predicted, related to the therapist as a person. The literature has commented on the importance of the gender of the therapist (Llewelyn, 1997), but other factors about 'who the therapist was' and 'how they acted' also seemed to be important. This ranged from the therapist being professional and competent to being sensitive and responsive. After reading the study findings, one of the CSA participants commented, 'we need a lot of reassurance don't

we'. The Rogerian characteristics of warmth, honesty and genuineness were also raised. The therapist factors are possibly the factors initially noticed and evaluated by the client and thus important in the early stages of establishing a relationship. The prominence of these factors in the interviews with the CSA group suggests that they may play an important role in helping these clients feel comfortable and able to engage with their therapist. It is from this basis that the client builds their trust and working relationships with their therapist.

Horvath et al. (1993) proposed that the development of the alliance occurs in two phases. In the first phase, which includes up to the first five sessions, collaboration and trust is established. Factors relating to the characteristics and interpersonal qualities of the therapist may be particularly important during this phase. In the second phase, therapeutic interventions centre on altering negative patterns of beliefs or behaviours. Horvath et al. (1993) suggest that in this phase the client may perceive a withdrawal of support and ruptures in the alliance may occur. The quality of the alliance then depends upon how these ruptures are dealt with.

The themes that emerged from the grounded theory analysis also related to particular stages of the development of the alliance. Characteristics of the therapist appeared more important at the beginning of therapy, and then as therapy progressed, the techniques and structure of therapy became more prominent. Both of these contribute to the overall perception by the client of their relationship with their therapist.

It was expected that the sample would contain clients who generally had a positive



relationship with their therapists, due to way that the participants were recruited. However, there were very few negative comments, despite the author specifically searching for them during the interview. Even problems or disagreements that arose in therapy were described in a positive light. This may reflect repairs to ruptures that occur in the alliance, which then serve to strengthen the alliance (Horvath et al., 1993). Thus, tackling disagreements or problems in therapy could serve to enhance therapeutic alliance, and then be viewed positively. Marziali (1984) found that clients and therapists were able to report both positive and negative alliance factors, suggesting that perception of negative qualities in the treatment partner did not preclude recognition of positive qualities.

#### **4.5 Clinical implications**

The participants interviewed were not selected to represent a wider population of clients, but were instead recruited in order to investigate the views and experiences of a particular group of women receiving therapy. Their experiences are not necessarily representative of other people receiving therapy. However, the findings of the study, used in addition to other research, could inform therapy with other groups of people.

The study does not provide evidence in support of any particular approach to therapy. Llewelyn (1997) points out that just as there is no theoretical consensus on understanding the effects of CSA, there is also no consensus on type of treatment. She says that instead treatment should be responsive to the individual client and that whatever approach is taken 'must be based on a sound therapeutic alliance'. Others have also stressed the importance of the therapeutic relationship when working with



survivors of abuse (Lebowitz et al., 1993).

The areas of importance raised in the interviews highlight areas that may be important in the early stages of therapy. Client's preconceptions about their therapist being a woman, or their views about the age of the therapist, may be important in the initial stages of forming an alliance. Gold (1986) suggests that the issues of trust highlight the importance of the therapist providing a supportive and non-judgmental environment. Draucker (1999) suggests that clinicians working with survivors of sexual assault should provide support, validation and empowerment.

This study provides support for factors that may be relevant to working with survivors of abuse, which have been discussed in the literature. These include factors related to the structural elements of the therapy, such as boundaries and client pace (Roth & Newman, 1993). Others include interpersonal qualities of the therapist, such as being caring, empowering and supportive (Crowder, 1995). A third group related more to characteristics of the relationships such as trust, respect, collaboration and safety (Lebowitz et al., 1993). These are all factors that the therapist could give particular attention to within a wide range of different therapeutic approaches.

This study found that, of the factors that were raised by the survivors of abuse, the majority were also mentioned by non-CSA. Whilst there were differences in the extent to which each group raised these factors, the findings do suggest that many of them are common to different types of people seeking therapy.

There were some areas of difference between the two groups, which may be of particular relevance to people working with survivors of CSA. Points that were pertinent to the CSA group included commitment from their therapist, open-ended or long-term therapy, feeling believed and that their therapist did not show negative reactions.

Identifying specific interpersonal beliefs that may influence the therapeutic relationship could serve to provide important information in identifying interpersonal schemata. The relationship with the therapist may also provide a means of challenging universal beliefs about relationships and their consequent cognitive distortions. Roth & Newman (1993, p.364) write that 'working through trauma may require a major re-examination of one's beliefs'. Janoff-Bulman (1985, p.23) also said that 'incorporating one's experience as a victim involves reworking one's assumptions about oneself and the world so that they "fit" with new personal data'.

#### **4.6 Future research**

Some of the differences predicted by the hypotheses were not found to be significantly different. A larger study would be needed to establish whether non-significant findings were a result of the small sample size, or whether the differences were, in reality, small. A larger study could investigate whether the CSA and non-CSA clients do differ in the types of interpersonal difficulties they experience and whether these differences affect the therapeutic alliance. Future research could also look at whether the differences found are also present among other groups of clients, such as male survivors of CSA.

The therapeutic relationship and the techniques of therapy have been often considered separately, although this distinction is not necessarily clear-cut (Butler & Strupp, 1986). In the current study, the participants' descriptions of what was important in forming a relationship with their therapist included characteristics of the therapist, and also of the therapy. Further research is needed to explore the relationship between choice of technique and the effect on alliance, and also how the alliance may influence the choice of therapy technique. CBT would perhaps offer a suitable therapeutic approach in which to study this, as the techniques are more defined than other therapeutic approaches.

Horowitz, Rosenbaum & Wilner (1988) point out that for a large percentage of clients therapy is not successful. Research has tended to concentrate on clients who have successfully formed positive therapeutic alliances. At least one study has shown that poor therapeutic alliance is predictive of dropout in therapy (Samstag et al., 1998). Research examining the views of clients who fail to form a successful relationship with their therapist, could prove useful in highlighting areas where therapists could improve. Particular pairings of clients and therapists have been suggested to result in poor alliance patterns (Horvath et al., 1993). Most studies, including this one, concentrate on studying the experiences of groups of clients. Further research could examine how the themes raised in this study differ between different combinations of clients and therapists. The different views of clients and therapists could also be explored to see if there are particular pairings where agreement and outcome is particularly high or low.

Horvath et al. (1993) point out that little has been written on specific techniques to



improve the therapeutic relationship, which therapists could use to improve dropout rates or dissatisfaction with therapy. Research aimed at highlighting helpful events in therapy, such as that conducted by Llewelyn, Elliot, Shapiro, Hardy & Firth-Cozens (1988), could also examine the effect of helpful events on the therapeutic alliance. Finally, research could look in more detail at disagreements or problems in therapy and the way ruptures in therapy are either successfully or unsuccessfully tackled.

#### **4.7 Conclusions**

The results from this study provided some support for the hypothesis that clients who were sexually abused as children have lower therapeutic alliance scores, although this was only shown on the WAI and not the HAQ-II. The CSA groups did not show an overall higher level of interpersonal problems, but did show significantly greater scores in being too aggressive compared to the non-CSA group.

The results from the qualitative analysis highlight a number of areas that appeared pertinent to survivors of abuse. These fell into three main themes, the characteristics of the therapist, such as age and interpersonal qualities; characteristics of the therapy, such as structure and techniques; and finally the clients' perceptions of the relationship. Women in the CSA group generated more comments about characteristics and qualities of the therapist, which are perhaps more important in the initial stages of therapy. They also talked more about the 'relationship' issues of trust, safety, acceptance and commitment of the therapist. The early interpersonal experiences of clients in the CSA group appeared to be related to some unique areas of concern for these clients, in being believed, the commitment of the therapist and not receiving negative reactions.

This study did not aim to produce results that are generalisable to other populations, however, the findings could be used to inform clinicians working with other groups of clients with traumatic interpersonal backgrounds. Finally, this study recognises that sexual abuse is just one type of abuse that occurs to children, which results in the disruption of the safe and nurturing interpersonal relationships that children require. This study does not suggest a causal link between sexual abuse and the differences identified because many of the individuals may have also experienced other forms of maltreatment in childhood.

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# **TEXT BOUND INTO THE SPINE**



# Working Alliance Inventory

Please circle one of the numbers which best relates to how much each statement applies to your experience with your therapist, scores range from 7 = always to 1 = never.

	Never					Always	
	1	2	3	4	5	6	7
1. I feel uncomfortable with my therapist.	1	2	3	4	5	6	7
2. My therapist and I agree about the things I need to do in therapy to help improve my situation.	1	2	3	4	5	6	7
3. I am worried about the outcome of these sessions.	1	2	3	4	5	6	7
4. What I am doing in therapy gives me new ways of looking at my problem.	1	2	3	4	5	6	7
5. My therapist and I understand each other.	1	2	3	4	5	6	7
6. My therapist perceives accurately what my goals are.	1	2	3	4	5	6	7
7. I find what I am doing in therapy confusing.	1	2	3	4	5	6	7
8. I believe my therapist likes me.	1	2	3	4	5	6	7
9. I wish my therapist and I could clarify the purpose of our sessions.	1	2	3	4	5	6	7
10. I disagree with my therapist about what I ought to get out of therapy.	1	2	3	4	5	6	7
11. I believe that the time my therapist and I are spending together is not spent efficiently.	1	2	3	4	5	6	7
12. My therapist does not understand what I am trying to accomplish in therapy.	1	2	3	4	5	6	7
13. I am clear what my responsibilities are in therapy.	1	2	3	4	5	6	7
14. The goals of these sessions are important to me.	1	2	3	4	5	6	7
15. I find that what my therapist and I are doing in therapy is unrelated to my concerns.	1	2	3	4	5	6	7
16. I feel that the things I do in therapy will help me to accomplish the changes that I want.	1	2	3	4	5	6	7
17. I believe my therapist is genuinely concerned for my welfare.	1	2	3	4	5	6	7
18. I am clear about what my therapist wants me to do in these sessions.	1	2	3	4	5	6	7
19. My therapist and I respect each other.	1	2	3	4	5	6	7
20. I feel that my therapist is not totally honest about his/her feelings towards me.	1	2	3	4	5	6	7
21. I am confident in my therapist's ability to help me.	1	2	3	4	5	6	7
22. My therapist and I are working towards mutually agreed upon goals.	1	2	3	4	5	6	7
23. I feel that my therapist appreciates me.	1	2	3	4	5	6	7
24. We agree on what is important for me to work on.	1	2	3	4	5	6	7
25. As a result of these sessions I am clearer as to how I might be able to change.	1	2	3	4	5	6	7
26. My therapist and I trust one another.	1	2	3	4	5	6	7
27. My therapist and I have different ideas on what my problems are.	1	2	3	4	5	6	7
28. My relationship with my therapist is very important to me.	1	2	3	4	5	6	7
29. I have the feeling that if I say or do the wrong things, my therapist will stop working with me.	1	2	3	4	5	6	7
30. My therapist and I collaborate on setting goals for my therapy.	1	2	3	4	5	6	7
31. I am frustrated by the things I am doing in therapy.	1	2	3	4	5	6	7
32. We have established a good understanding of the kind of changes that would be good for me.	1	2	3	4	5	6	7
33. The things that my therapist is asking me to do doesn't make sense.	1	2	3	4	5	6	7
34. I don't know what to expect as the result of my therapy.	1	2	3	4	5	6	7
35. I believe that way we are working with my problem is correct.	1	2	3	4	5	6	7
36. I feel my therapist cares about me even when I do things that he/she does not approve of.	1	2	3	4	5	6	7

# Helping Alliance Questionnaire

These are ways that a person may feel or behave in relation to another person - their therapist. Consider carefully your relationship with your therapist, and then mark each statement according to how strongly you agree or disagree. *Please mark every one.*

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1. I feel I can depend upon the therapist.						
2. I feel the therapist understands me.						
3. I feel the therapist wants me to achieve my goals.						
4. At times I distrust the therapist's judgement.						
5. I feel I am working together with the therapist in a joint effort.						
6. I believe we have similar ideas about the nature of my problems.						
7. I generally respect the therapist's views about me.						
8. The procedures used in my therapy are <i>not</i> well suited to my needs.						
9. I like the therapist as a person.						
10. In most sessions, the therapist and I find a way to work on my problems together.						
11. The therapist relates to me in ways that slow up the progress of the therapy.						
12. A good relationship has formed with my therapist.						
13. The therapist appears to be experienced in helping people.						
14. I want very much to work out my problems.						
15. The therapist and I have meaningful exchanges.						
16. The therapist and I sometimes have <i>unprofitable</i> exchanges.						
17. From time to time, we both talk about the same important events in my past.						
18. I believe the therapist likes me as a person.						
19. At times the therapist seems distant.						

# INVENTORY OF INTERPERSONAL PROBLEMS – 32

Name: .....

Date: .....

Here is a list of problems that people report in relating to other people. Please read the list below, and for each item mark with an X the box which indicates how distressing that problem has been for you.

## EXAMPLE

How much have you been distressed by this problem?

It is hard for me to:

Get along with relatives

Not at all	A little bit	Moder- ately	Quite a bit	Extre- mely
0	1	2	3	4

**Part 1: The following are things you find hard to do with other people.**

It is hard for me to:

	Not at all	A little bit	Moder- ately	Quite a bit	Extre- mely
1. join in groups	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2. be assertive with another person	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3. make friends	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4. disagree with other people	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
5. make a long term commitment to another person	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
6. be aggressive toward other people when the situation calls for it	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
7. socialise with other people	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
8. show my feelings to people	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
9. feel comfortable around other people	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
10. tell personal things to other people	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
11. be firm when I need to be	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
12. experience a feeling of love for another person	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
13. be supportive of another person's goals	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>



## Appendix 6.1.3

	<input type="checkbox"/> Not at all	<input type="checkbox"/> A little bit	<input type="checkbox"/> Moder- ately	<input type="checkbox"/> Quite a bit	<input type="checkbox"/> Extre- mely
14. really care about other people's problems	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. put someone else's needs before my own	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. take instructions from people who have authority over me	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. open up and tell my feeling to another person	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. attend to my own welfare when somebody else needs help	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. be involved with another person without feeling trapped	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Part II: The following are things that you do too much

	Not at all	A little bit	Moder- ately	Quite a bit	Extre- mely
20. I fight with other people too much	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I get irritated or annoyed too easily	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. I want people to admire me too much	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. I am too dependent on other people	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. I open up to people too much	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I put other people's needs before my own too much	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. I am overly generous to other people	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. I worry too much about other people's reactions to me	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. I lose my temper too easily	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. I tell personal things to other people too much	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. I argue with other people too much	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. I am too envious and jealous of other people	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. I am affected by another person's misery too much	0	1	2	3	4
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Client-Therapist Ratings Scale

This short questionnaire asks clients and their therapists to rate how they have worked together, or are still working together. Please circle one number between 1 and 7, on each scale, which best relates to how much you agree to each of the five statements.

- 1. The client and therapist agreed/agree on the goals of therapy. The goals of therapy are the things you want to achieve at the end of therapy.**

Not at all						Completely
1	2	3	4	5	6	7

- 2. The client and therapist agreed/agree on the tasks of therapy. The tasks of therapy are the steps you need to take to reach your goals.**

Not at all						Completely
1	2	3	4	5	6	7

- 3. The bond between client and therapist was:**

Very poor						Very good
1	2	3	4	5	6	7

- 4. The therapist provided, or could provide, the help needed.**

Not at all						Completely
1	2	3	4	5	6	7

- 5. The therapist and client worked well together in therapy.**

Not at all						Completely
1	2	3	4	5	6	7

## Semi-structured interview schedule

Client number: .....

Age: .....

Sex: M / F

Marital Status:

Single / married-cohabit / divorced

/ widowed

Living arrangement:

alone / partner / parents / siblings / other relative / friends /  
house-share / children

Employment:

f/t paid / p/t paid / housewife / unemployed / long-sick / p/t  
student / f/t student / other .....

Previous Psychiatric Tx: Yes / No

Previous Psychological Tx: Yes / No

Therapist:

Number of sessions:

### INTRODUCTION:

I'd like to ask you to think about your recent experience of therapy or counselling and to think about the things that were helpful and unhelpful in the way that you and your therapist worked together. Could you tell me a bit about the things do you think were important in the relationship you have with your therapist.

### Additional prompt questions:

1. Was there anything that your therapist did that was particularly helpful?
2. Was there anything that your therapist didn't do that would have been helpful?
3. Was there anything that your therapist did that was unhelpful?
4. Is there anything they could have done differently to make things easier?
5. If you were to give your therapist a piece of advice about therapy what would it be?



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Claire Middle & Dr Helen Kennerley: Department of Psychology, Telephone: 01865 223968

## An evaluation of the therapeutic alliance

I would be very grateful if you could complete the following checklist for .....  
who has agreed to take part in this study, this should only take a few minutes to do. Please could you  
send it back to me in the stamped addressed envelope.

### Main problem:

Please circle the MAIN target problem of therapy.

Tick ✓ any other important problems, whether treated or not.

- |                                |       |
|--------------------------------|-------|
| General anxiety                | _____ |
| Health anxiety                 | _____ |
| Social phobia                  | _____ |
| Specific phobia                | _____ |
| Agoraphobia                    | _____ |
| Panic disorder                 | _____ |
| Obsessional disorder           | _____ |
| Depression                     | _____ |
| Anorexia                       | _____ |
| Bulimia                        | _____ |
| Binge eating disorder          | _____ |
| Relationship problems          | _____ |
| Anger problems                 | _____ |
| Post traumatic stress disorder | _____ |
| Psychotic symptoms             | _____ |
| Other                          | _____ |
| (please specify) .....         |       |

Has this person disclosed a history of childhood sexual abuse?

Yes / No

Thanks  
Claire Middle

**Oxford  
Radcliffe**

**OXFORDSHIRE PSYCHIATRIC RESEARCH  
ETHICS COMMITTEE**

Manor House  
Headley Way, Headington  
Oxford OX3 9DZ

Tel: 01865 222692/222547  
Fax: 01865 222699

Our Ref: DG/eb/098.40

9th September 1998

Dr Helen Kennerley  
The Psychology Dept  
Warneford Hospital  
Oxford

Dear Dr Kennerley

Re: OPREC 098.40 - An evaluation of the therapeutic alliance: A comparison between clients sexually abused as children and non-abused clients

This study was reviewed at the OPREC meeting on the 8<sup>TH</sup> September 1998 and has ethical approval subject to the minor modification to appendix 4a to read - in the second paragraph - "either ask for directions".

May we remind you that OPREC final approval is contingent on the appropriate indemnity.

Kind regards

Yours sincerely,

*Alison G Riches*

Dr D Geaney  
Chairperson  
Oxfordshire Psychiatric Research Ethics Committee

Chairperson: Dr D. Geaney

**Northampton Medical Research/Ethics Committee**  
**Chairman:** Mr Fred Evans  
**Secretary:** Miss Michelle Skelton ☎ (01604) 615363



Our Ref: FE/MS/99/02

12 March 1999

Dr Helen Kennerley  
 Consultant Clinical Psychologist  
 The Psychology Department  
 Warneford Hospital  
 OXFORD  
 OX3 7JX

Dear Dr Kennerley

**99/02 AN EVALUATION OF THE THERAPEUTIC ALLIANCE: A COMPARISON  
 BETWEEN CLIENTS SEXUALLY ABUSED AS CHILDREN AND NON-ABUSED  
 CLIENTS**

The Northampton Medical Research/Ethics Committee reviewed your response to their concerns in relation to the above study at their meeting on 11 March 1999. I am pleased to inform you that the Committee were satisfied with the amendments which have been made and have granted Formal Ethical Approval for the study to proceed.

To complete our records regarding the project, I would be grateful if you could complete and return the form accompanying this letter.

Please let me know if the study has to be terminated or any ethical considerations arise which need to be discussed further by the Committee.

Yours sincerely

Michelle Skelton  
 Secretary, Northampton Medical Research/  
 Ethics Committee



Northamptonshire Health Authority, Highfield, Cliftonville Road,  
 Northampton NN1 5DN Tel: 01604 615000 Fax: 01604 615010  
 Chairman: Simon Schanschieff OBE, FCA, JP Chief Executive: Lynda Hamlyn BA(Hons)





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## INFORMATION SHEET

### An evaluation of the therapeutic alliance

Research has shown that the way that clients and their therapist or counsellor work together is important in how well people do in therapy and counselling. People differ in how easily they find working with their therapist or counsellor. We want to investigate what factors explain these differences. This study aims to help us understand what helps clients and their therapists work together, and to gather ideas on how to improve the help offered to people in the future.

To do this we would like to ask people who are having therapy or counselling, or have recently completed therapy or counselling, about the way they worked with their therapist or counsellor. We would like to know about the things that were helpful and unhelpful in working together. As people are not the same, it is important that we speak to different types of people about their experiences. We hope to include both men and women, people of different ages and backgrounds, people who have experienced traumatic events in childhood and those who haven't, and people who have long-standing problems as well as more recent difficulties. Your involvement in this study would offer a very important piece to the study.

We will ask your counsellor or therapist to tell us very briefly what type of difficulties brought you to therapy or counselling, but we will not ask about details of what you've discussed during your sessions. We will also be asking your therapist or counsellor to fill out a very brief questionnaire so we can see whether clients and therapists differ in their views. All the information given will be completely confidential and therapists will not be told what their clients have said.

#### What would it involve?

Taking part in this study would involve one meeting with me. We can meet either at your home or at the Psychology Department at the Warneford Hospital, whichever you prefer (travel costs to the Warneford hospital by bus or train will be reimbursed). I will ask you to fill in some questionnaires and take part in a short interview. This meeting is likely to last up to one hour. I would like to audio-tape this meeting to help me remember all that is said, and so I won't have to take lots of notes when we meet. Everything you tell me will be confidential and the audio-tapes and questionnaires will be stored in a secure place. The interviews will only be listened to by myself and one other researcher, and the tapes will be destroyed once the study has been completed.

You are free to withdraw from the study at any time. During the interview you can stop at any time and you do not have to answer anything you don't want to. Your decision whether or not to help with this study will not affect any future or current treatment.

If you have any questions about the study, please ring me on the number above. If I am not there, or unable to take your call, please leave a message and I will get back to you as soon as I can. Your help with this project would be greatly appreciated.

Claire Middle  
Researcher



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Claire Middle & Dr Helen Kennerley: Department of Psychology, Telephone: 01865 223968

## ROYAL COLLEGE OF PHYSICIANS CONSENT TO RESEARCH FORM

**Title of project:** An evaluation of the therapeutic alliance

**Name of Principle Investigator:** Dr Helen Kennerley

**Psychiatric Research Ethics Committee Application Number:** O98.40

*Please circle you answer for the following questions.*

Have you read the Patient Information sheet? Yes / No

Have you had an opportunity to ask questions and discuss this study? Yes / No

Have you received satisfactory answers to all your questions? Yes / No

Have you received enough information about the study? Yes / No

Who has explained the study to you? Dr / Mr / Mrs / Ms .....

Do you understand that you are free to leave the study

- at any time
- without having to give a reason for leaving
- and without affecting your treatment? Yes / No

Do you agree to take part in this study? Yes / No

Do you agree to the interview being audio-taped? Yes / No

Signature: .....

Date: .....

Name in block letters: .....



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Claire Middle & Dr Helen Kennerley: Department of Psychology, Telephone: 01865 223968

## An evaluation of the therapeutic alliance

Thank-you very much for taking part in this study, your contribution is important in helping us to understand what helps in treatment. The interview is unlikely to be distressing but if you do feel upset you may want to talk to someone about how you feel, such as your therapist, or a friend or relative who you trust. Below are the telephone numbers of three help-lines that have people to speak to. If you are worried about anything we have talked about, or you have any questions about anything we have discussed, please do phone me on the number above.

The Samaritans:	(01865) 722122
Oxford Sexual Abuse & Rape Crisis:	(01865) 726295
Oxford Mind:	(01865) 511702

If you feel that you need to talk to someone urgently and there is no one available on the above numbers, you can always contact your GP surgery as an emergency.

Finally, here are a few titles of books that people have found helpful in the past.

Outgrowing the Pain (1983)  
written by E. Gil & published by Dell books.

Breaking Free (1993)  
written by C. Ainscough & K. Toon & published by Sheldon Press.

Once again, many thanks for your help with this study, your contribution is very important.

Claire Middle  
Researcher



**EXAMPLES OF CODING CATEGORIES**

<b>CSA Group:</b>	<b>"Therapist's age"</b>
Pt 2; paragraph 21	"She's a mature woman."
Pt 4; paragraph 3	"Being a bit older than me, a father figure."
Pt 21; paragraph 2	"I think definitely the fact of her age"
paragraph 18	"Her age, does she represent a mother figure? She's about the same age as my mother"
Pt 23; paragraph 7	"He's quite young, which I think probable helped with me. I would have found it much more difficult to relate to somebody much older than me just because they would probably have different views and things."
Pt 25; paragraph 10	"She's a lot younger than I am and that did bother me at one time."
Pt 26; paragraph 11	"I think it's that she's so young, that helps."

<b>CSA Group:</b>	<b>"Safe and secure"</b>
Pt 2; paragraph 1	"I just feel safe to be anything."
paragraph 4	"She made me feel safe."
Pt 3; paragraph 2	"You don't want to let go, it's your bit of security. Everyone needs security, she gave me that."
Pt 7; paragraph 2	"I realised that I wasn't going to be thrown out."
Pt 11; paragraph 10	"A safe place to talk about all the things that you can't talk about anywhere else."
Pt 16; paragraph 8	"I feel secure enough that I've not questioned him."
Pt 21 paragraph 20	"It's the one safe place I've got."

<b>Non-CSA Group:</b>	<b>"Understands"</b>
Pt 1; paragraph 7	"She understands me pretty well."
Pt 5; paragraph 1	"I did feel that she understood me."
Pt 10; paragraph 1	"He knew exactly how I felt."
paragraph 2	"He understood."
paragraph 5	"He just understood me so well."
Pt 19; paragraph 2	"He always seemed to understand me."
paragraph 10	"I felt he knew me quite well."
paragraph 15	"He just seemed to know my mind so well."
Pt 20; paragraph 4	"An understanding of my feelings."
paragraph 6	She saw immediately what it was."

**RESEARCH DIARY (summarised)**

Sept 1998	Ethics committee approval granted.
Oct/Nov 1998	Speak with services about procedures and what is involved in the study. Distribute information sheets and reply slips.
Dec 1998	Begin interviewing participants. Expecting clients from group one to raise more interpersonal issues such as to trust and blame, and factors such as understanding and not being judged will be important.
30 Jan 1999	First five interviews for group 1 participants coded. Wide range of themes and issues raised from trust to being liked, personality of the therapist to boundaries.
1 Mar 1999	Eight interviews for group 1 participants coded. Common themes: being listened to, trust, not being judged, being believed and taking time to talk about personal things. Split category: responsive & encouraging. Merge categories: discussing priorities of client & listening to what I wanted.
9 Mar 1999	Eleven interview for group 1 participants coded. 61 codes created. Two broad themes emerging: 1) Feeling comfortable 2) Meeting the needs of the client.
28 Mar 99	Coded 9 interviews for group 2.
17 May 99	Review of codes based on 14 interviews in group 1 and 9 interviews in group 2. Broad categories emerging from the data are 1) therapist characteristics, 2) environmental factors, 3) therapy factors, 4) specific actions, 5) therapist manner, and 6) way the client feels. Difficulty finding participants – re-distribute all information and arrange to talk individually to as many therapists as possible.
25 May 99	Merge “get on” with “close connection and collaboration” Merge “explain action” and “admit if don’t know”.
8 Jun 99	New codes: Timing, Helps & progress Merge codes: “not patronising” with “genuine and honest” “help with family” with “practical help” and “new perspective” “no touch” with “sensitivity” “treatment helps”
16 Jun 99	Review of group 1 codes based on 17 interviews; check all transcripts and cards. Take to supervision and agree 6 main categories organised into 3 themes: A. The therapy: 1. Structural factors / 2. Techniques B. The therapist: 3. Fixed characteristics / 4. Interpersonal qualities C. Client perceptions of relationship: 5. Feelings about therapist / 6. Clients feelings Reviewed content of categories and merged codes and reduced 62 codes to 33. Merged codes: 1. “begin session” with “environment” / “boundaries” includes “timing”, “duration”, “disclosure” / “structure” with “focus” 2. “advice” includes “practical” and “literature” / “different perspective/normalise” 4. “sensitivity” with “responsive” / “cares”, “encourages”, “reassures”, “personality”



	<p>/ "honest and genuine" includes "admit if don't know/explains" / "professional" includes "competent" and "works or helps"</p> <p>5. "close connection/collaboration" with "dependency"</p> <p>6. "accept" with "non-judgmental" and "believed" / "comfortable" with "able to cry" / "important" with "liked" / "discuss difficult things with "open", "raising problems" / "safe and secure" with supportive" / "working in own time" with "what client wanted" and "flexibility"</p>
17 Jun 99	Codes for interview 2 (based on 11 interviews) put into the above framework, data not available for 3 codes, otherwise all other codes used.
18 Jun 99	<p>Review categories again in supervision and made minor changes.</p> <p>Split out "personality" back into own code.</p> <p>Now 34 codes into 6 categories and 3 themes.</p>
21 Jun 99	<p>Day concentrating on writing account of CSA interviews based on themes emerged, reading through the cards and reading the research diary. Plan to continue with account over the following 2 weeks. Two interviews planned for this week.</p> <p>Currents 17 in group 1 and 12 in group 2. Excluded one participant from the analysis as he is the only man (groups not matched by sex otherwise).</p>
24 Jun 99	<p>The account – emerging differences specific to CSA group:</p> <p>Therapy structure: more open-end, confidentiality, commitment and environment.</p> <p>Therapy techniques: points of fact, recapping, specific help. Same new perspective.</p> <p>Therapist characteristics: more comments on age and gender, similar on training</p> <p>Therapist qualities: more professional, honest, reassure, no alarm</p> <p>Feelings to therapist: more on trust, respect, less friends and more worry their view.</p> <p>Client's feelings: difficult things, being upset, accepts &amp; believed</p>
26 Jun 99	<p>Re-order to discussing therapist factors before therapy factors as this seems to better reflect the experiences of clients. Although there was no definite pattern in the order in which client raised different factors, I began to think about the way the client would experience the different categories mentioned in a sequential order. Decided that client's may first notice things about the therapist, 'who they are' e.g. age and sex, and next 'how they act', i.e. interpersonal qualities. As clients become engaged in therapy the structural and techniques of therapy then become more known. The client perceptions appears to reflect the things of conclusions the client has drawn about their therapist, i.e. how they feel about them and how the therapist makes them feel. Account re-written to reflect this sequence.</p>
29 Jun 99	<p>Supervisor coded quarter of interviews: commented that it was quite a difficult exercise, involved much interpretation and judgement on part of rater, also the written transcript and loss of contextual factors made some parts of interviews difficult to understand. Inter-rater reliability calculated on the 34 coding categories. Found that 91% of the codes show 67.5% agreement or more, &amp; 73% had 75% agreement or more. Poor agreement on codes therapist cares, structure and close connection and collaboration.</p>
2 July 1999	Feedback session with client from CSA group to discuss findings. Agree generally.
9 July 1999	Feedback session with second client from CSA group to discuss findings.



## **THEMES AND CATEGORIES USING IN INTERVIEW ANALYSIS**

### **A. THERAPY**

#### **1. The structure of therapy**

- 1.1 Beginning and end of sessions, environment therapy set in
- 1.2 Boundaries, disclosure, duration and time limits in therapy
- 1.3 Commitment to therapy by the therapist
- 1.4 Confidentiality
- 1.5 Structure, guidance, focus and direction

#### **2. The techniques of therapy**

- 2.1 Advice, practical suggestions, points of fact, literature and practical help
- 2.2 Different perspective or alternative explanations, normalising
- 2.3 Confidence building and giving praise to the client
- 2.4 Helping the client to find their own solutions or word
- 2.5 Recapping or remembering previous sessions

### **B. THE THERAPIST**

#### **3. Fixed characteristics of the therapist**

- 3.1 Age of the therapist
- 3.2 Gender of the therapist
- 3.3 Training, education and knowledge of the therapist

#### **4. Interpersonal qualities of the therapist**

- 4.1 Sensitivity (includes body language), responsive and perceptive
- 4.2 Cares and empathises, encourages & reassures
- 4.3 Honest and genuine, admit if don't know
- 4.4 Humour
- 4.5 Listens to their client
- 4.6 Not alarmed or react badly
- 4.7 Pace is soft and gentle
- 4.8 Personality friendly, approachable personality
- 4.9 Professional & competent

### **C. CLIENT PERCEPTIONS OF THE RELATIONSHIP**

#### **5. How the client feels about the therapist**

- 5.1 Close connection or collaboration, not dependent
- 5.2 Consider the therapist as a friend
- 5.3 Respect
- 5.4 Trust
- 5.5 Worries about how the therapist views the client

#### **6. How the therapist makes the client feel**

- 6.1 Accepted and not judged, believed
- 6.2 Feels comfortable, able to cry and be upset
- 6.3 Feel important and valued, & liked by the therapist
- 6.4 Can discuss difficult things, open and can raise problems & disagreements
- 6.5 Feel safe and secure, feel supported by the therapist
- 6.6 Feel understood
- 6.7 Able to talk about what is important to the client, flexibility